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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Indonesia

SUMMARY

The Executive Director recommends that the Executive Board approve the country programme of Indonesia for the period 1995-2000 in the amount of \$72,000,000 from general resources, subject to the availability of funds, and \$70,000,000 in supplementary funds, subject to the availability of specific-purpose contributions.

CONTENTS

	<u>Page</u>
THE SITUATION OF CHILDREN AND WOMEN	2
PROGRAMME COOPERATION, 1990-1994	4
RECOMMENDED PROGRAMME COOPERATION, 1995-2000	9

List of tables

1. Basic statistics on children and women	18
2. Expenditure under previous cooperation period, 1990-1994	20
3. Planned expenditure, 1995-2000	21

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).



THE SITUATION OF CHILDREN AND WOMEN

1. Over the past 25 years, Indonesia has enjoyed a stable Government, sustained economic growth and rapid social development. Annual per capita income has increased from \$70 to approximately \$700 and the number of people living in poverty has dropped from about 70 million, or 60 per cent of the population, to some 30 million, or 15 per cent of the population. The population is becoming urbanized at the rate of about 4 per cent per year and, by the year 2000, it will be between 40 and 50 per cent urban. The total fertility rate was reduced from 5.6 in 1968 to 2.8 in 1993. Improvements in the provision of social services have kept pace with economic growth, especially in terms of improved access. Extensive health and education systems are now in place, with primary schools in all villages and health centres in every subdistrict. However, the utilization of health services is still low, especially among the poorest; 40 per cent of the poor do not utilize the formal health service when sick. While economic improvement has been rapid, Indonesia is still a relatively low-income country. Many people live just above the official poverty line, which was \$10 per month in 1993.

2. Indonesia's remarkable development record is attributable largely to a strong and tightly budgeted central planning process; 25-year and 5-year national development plans are elaborated and budgets are allocated in accordance with the Guidelines of State Policy provided by the People's Consultative Assembly. Yearly implementation plans and budgets are elaborated after considering the aspirations of the provinces based on a bottom-up, consensus-seeking planning process which begins with village-level discussions. The social sector regularly gets more than 20 per cent of government development budgets, which is in line with the principles of the State ideology as manifested in the trilogy of development: equity, growth and stability.

3. Between 1976 and 1993, the infant mortality rate (IMR) was reduced from 108 to 58 per 1,000 live births and the under-five mortality rate (USMR) from 162 to 81 per 1,000 live births.* If those trends continue, the goals for children for the decade are likely to be met. Virtually 80 per cent of child diarrhoeal cases are treated with oral rehydration therapy (ORT) or appropriate household fluids. More than 80 per cent of infants are vaccinated in 96 per cent of provinces and 93 per cent of districts and cities. Coverage of tetanus toxoid immunization among pregnant women is currently at 67 per cent, and with the new community midwives being deployed it should reach 80 per cent nationally by 1995. Acute respiratory infections (ARI) have overtaken diarrhoea as the major cause of child deaths. The mid-decade disease reduction targets for poliomyelitis, measles and neonatal tetanus should be achieved through the national immunization weeks to be carried out in 1995.

4. Because the health and nutrition status of women is of special concern, relevant goals will be reached only through special efforts. The maternal

* Official rates are a little higher than the country office estimates which are based on census data trends.

mortality rate (MMR) is high at 425 per 100,000 live births (1993). Chronic energy deficiency affects one third of women, while two thirds of pregnant women are anaemic. Although access to family planning services has improved considerably and 80 per cent of the demand for such services are met, only 54 per cent of pregnant women have four antenatal contacts with the health system. Seventy per cent of births are not medically supervised and only 30 per cent of district-level referral hospitals have the capacity to perform essential obstetric functions. Accurate data on the incidence of sexually transmitted diseases and gynaecological infections are limited, but the rate is thought to be high and likely to contribute to women's low-grade morbidity. Although the official number of reported cases of acquired immunodeficiency syndrome (AIDS) is small, there is cause for concern as the number is increasing rapidly. If the health and nutrition goals for women are to be met, increasing attention must be paid to the underlying and basic causes.

5. Achieving other nutrition goals will require considerable effort. Some 45 per cent of pre-school children were under weight in 1992, down from 51 per cent in 1986, and this trend will have to be accelerated. Low birth weight affects 14 per cent of newborns. Malnutrition rates are 30 per cent higher in rural than urban areas, but in both areas, growth retardation usually occurs during the first year of life. As poverty is reduced, the targeting of efforts to improve household food security for macronutrients becomes more important. However, many households are also insecure for the micronutrients iron and iodine. Iodine deficiency disorders afflict between 10 million and 20 million people, several million of whom are affected by serious forms, including cretinism. Some 45 per cent of households consume adequate amounts of iodized salt, but universal iodization of edible salt should be achieved by the end of 1995 by mobilizing demand since the industrial capacity to iodize salt seems sufficient. While 89 per cent of mothers breast-feed for more than 12 months, only 30 per cent did so exclusively in 1992. With extra effort, the mid-decade goal of the Baby-Friendly Hospital Initiative can be achieved, with resulting positive consequences for exclusive breast-feeding.

6. Access to safe drinking water increased from 35 per cent in 1971 to 63 per cent in 1993, with improved access in urban areas (84 per cent) than in rural areas (53 per cent). The goals for water supply are likely to be achieved in urban areas if current trends are maintained. Latrine access is less satisfactory; in 1993, only 52 per cent of houses had latrines, with higher proportions in urban (79 per cent) than rural areas (39 per cent). Achieving the goals for sanitation will require a special effort involving a broad mobilization of many sectors in society.

7. Current trends indicate that the basic education goals either have been or are likely to be met. In 1992, over 90 per cent of children entered primary school and 79 per cent completed six years of primary education. In 1994, compulsory primary school was extended from six to nine years. While 13 per cent of adults are illiterate, the goal of reducing the illiteracy rate to 6 per cent is likely to be met. Improving basic life skills remains a challenge for the future and better caring practices for women and children need particular attention.

8. The situation concerning gender in Indonesia is positive and improving rapidly. Primary school enrolment rates are virtually equal for boys and girls. In younger children, biological vulnerability seems to prevail, and morbidity, mortality and malnutrition rates are higher for boys than for girls. The prevailing social and cultural climate does not yet fully support efforts to reduce gender-related disparities between women and men. Primary school completion rates are higher for boys (84 per cent) than girls (75 per cent). Legal protection of female workers and their occupational health and safety are not yet adequate, and their wages tend to be lower than those of male workers.

9. Social development has made great strides in Indonesia over the last few decades. Access to basic health and educational services has become almost universal and most educational goals have been met. While considerable progress has been made in the area of child survival, child malnutrition remains a problem and may be linked to the high maternal malnutrition and mortality rates. Future efforts should concentrate on understanding the community-level issues that determine the low utilization of health services, especially by the poor and by women. Maternal mortality is a priority issue and success in reducing it will have important "spill over" benefits for child survival and development (CSD).

PROGRAMME COOPERATION, 1990-1994

10. Indonesia participated in preparations for the World Summit for Children, and many of the principles and objectives of its Plan of Action were incorporated in the fifth five-year development plan, known as Repeleta V, and reflected in the previous programme of cooperation with UNICEF. The World Summit goals have been incorporated almost completely in Repelita VI, covering the period 1994-1999.

11. Through assistance to the core services of immunization, nutrition, maternal and child health (MCH), control of diarrhoeal diseases (CDD) and water supply and environmental sanitation, UNICEF contributed to the reduction of infant and child mortality. The nationwide assistance provided through the 245,000 community-based integrated health service posts called posyandus was more successful for immunization than for nutrition. UNICEF encountered coordination problems in its support for capacity-building to enhance community development, non-formal education and women's income generation in selected areas, and to strengthen district and city government management of basic services. UNICEF national-level advocacy and social mobilization support to promote the role of women in CSD, especially through religious leaders, became increasingly successful.

Health

12. With significant assistance from the World Health Organization (WHO), the United States Agency for International Development and Rotary International, UNICEF supported the successful universal child immunization effort by providing supplies and assistance for capacity-building. The involvement of local governments in monitoring helped to raise immunization coverage levels which have continued to increase since 1990, while external support has been

dramatically reduced. The elimination of neonatal tetanus is proving more difficult as it requires a coordinated effort between the immunization and MCH programmes.

13. Progress was uneven in the control of ARI and diarrhoeal diseases. The blanket provision of oral rehydration salts (ORS) through posyandus has been successful. National capacity to produce ORS exists and its commercial distribution is increasing. Various surveys developed in collaboration with WHO indicate that household management of diarrhoeal diseases is better than the management of cases referred to health centres. Although households provided ORT in 78 per cent of cases and medical attention was sought in 60 per cent of cases, only 15 per cent of cases at health centres are treated adequately. The control of ARI is still confined to the health posts, but when ARI occur, traditional birth attendants are consulted, most frequently at the community level. Success in the development of community-based approaches to ARI will depend on forging links with the community midwives of the MCH programme and posyandus.

14. Improved models for community midwife management, developed in 8 of the 27 provinces, are currently being taken to scale by the Government. In an attempt to improve the management and supervision of MCH-related programmes at the district level, trials were carried out in six provinces to develop integrated approaches to national MCH and nutrition programmes. An integrated local area system was developed to monitor coverage of MCH and nutrition services.

Nutrition

15. Blanket distribution of micronutrient supplements has been more successful than targeted distribution. Vitamin A capsules provided with supplementary funds from the Government of Switzerland and distributed through posyandus by UNICEF, in collaboration with the Helen Keller Institute, reached 60 per cent of children between one and five years of age, meeting the Repelita V target for the control of vitamin A deficiency. Coverage rates for iron pills provided by UNICEF, to pregnant women are less well known, but thought to be low. A baseline study to evaluate iodine capsule distribution in five provinces showed that prior iodine injections had little impact on goitre prevalence in heavily endemic areas. The targeting of the supplements seems not to have worked. In addition, in many control areas that previously had been only moderately endemic and dependent on iodized salt for prevention, goitre rates were worse. Public knowledge of the benefits of iodized salt is poor. District-level capacity was created to measure the iodine content of salt produced, but control mechanisms remain weak at the district level.

16. Growth monitoring has been widespread in Indonesia for more than a decade. Using supplementary funds provided by the Government of Switzerland, UNICEF has provided weighing scales and "Road to Health" growth monitoring and promotion charts for posyandus nationwide. Up to 5 million pre-school children are weighed monthly at posyandus by women volunteers from the Family Welfare Movement. Because programme reviews found the training of these volunteers to be too complex and didactic, participatory adult learning methods were developed and implemented. However, the use of growth monitoring information at family

and village levels remains ineffective. Child growth promotion needs to be developed further, taking into account local cultural needs.

17. A review of nutritional surveillance activities early in the programme period suggested the need for a common understanding of the role of related sectors in preventing malnutrition. While many good sectoral information systems exist, centralized decision-making processes weaken localized intersectoral planning. UNICEF programme support to nutrition surveillance focused on improving the surveillance of chronic energy deficiencies in women, and this preliminary work will need to be consolidated and expanded in the next programme cycle.

Water supply and environmental sanitation

18. In the 17 districts and 10 cities selected, water supply and environmental sanitation activities have shown a gradual shift of emphasis during the period, from a supply-driven approach supporting government construction of facilities to a community self-help approach. With supplementary funds from the Governments of Canada and Japan, the new approach included an increased emphasis on providing protected dug-wells; the provision of partial costs or construction materials to encourage community construction of latrines, wells and rainwater collectors; the distribution of fibreglass moulds to villages to improve the quality of community construction; and increased participation by women from the Family Welfare Movement in the formation of village-level water and sanitation groups. In selected areas, the use of these approaches led to dramatic improvements in coverage rates and universal access.

Education

19. As literacy rates rise, reaching the remaining illiterate population becomes increasingly difficult. A review of the combined income-earning and literacy project found that beneficiaries often were not the poorest women and that literacy activities often were neglected in favour of exclusive income earning. As a result, a stronger focus on literacy was instituted, new methods for detecting illiterates were implemented and local and culture-specific supplementary learning materials were developed. Assistance to formal basic education focused on the promotion of child survival through Islamic educational institutions in selected areas. UNICEF support to early childhood development, which uses a community-based approach in which volunteers teach mothers how to stimulate and interact with their children three years old and younger, has been particularly successful. The programme was elevated to the status of a national movement by the President and has spread throughout Indonesia.

Advocacy and social mobilization

20. Cooperation with religious organizations is growing. The child survival project, established in 1986 to promote basic life skills through religious organizations, expanded to involve over 20 Muslim, Protestant, Catholic and Hindu organizations in 14 large provinces. Some 25,000 female motivators have regular contacts with about 7 million people, providing educational and motivational guidance related to the survival and development of women and children. At the subdistrict level, Islamic marriage counsellors were mobilized

to ensure that brides-to-be were immunized against tetanus. The Supreme Council of Islamic Scholars receive assistance to discourage early marriage and to support the promotion of clean water and sanitation. Information on issues relevant to the basic needs of children and women was distributed regularly for inclusion in Friday sermons.

21. Indonesia has explicit policies on women's development and has ratified the Convention on the Elimination of All Forms of Discrimination against Women. Through the Office of the State Minister for the Role of Women, gender training was carried out for high-ranking officials from all sectors at central and provincial levels and for leaders of non-governmental organizations. UNICEF assistance enabled the National Breast-feeding Movement to promote a national baby-friendly hospital competition. Presidential awards have been given each year since 1991 to the two best hospitals in each of the 27 provinces. UNICEF assistance helped to strengthen the capacity of the Family Welfare Movement to manage the activities of the 2 million women volunteers who run posyandus in all provinces, as well as to provide each member with motivational skills to orient 10 households on issues related to the survival and development of women and children.

22. As the nation becomes increasingly urbanized, there is increasing concern for the situation of children in especially difficult circumstances. As an input to a project of the International Labour Organization (ILO), UNICEF developed and funded a study on child labour at the request of the Office of the Minister Coordinator for People's Welfare. The study identified reasons why children enter the workforce and factors that keep them in school, as well as a series of cultural factors important for maintaining family integrity. Programme experience with child protection issues needs to be developed further.

Lessons learned

23. Progress towards the objectives of reducing infant and maternal mortality and of improving nutrition was reviewed annually. While performance was notable for the child survival goals of immunization, ORT and vitamin A distribution, it was less satisfactory for the child malnutrition and maternal mortality goals, which require more complex interventions through an integrated and multisectoral approach. Reviews also indicated that utilization of health services by the poor is low and that the quality and targeted outreach of health services need improvement. In addition, the current standardized programme approach should suit local cultural and societal needs.

24. In order to try to understand why integrated approaches were not effective, the mid-term programme review focused on the cross-sectoral issues of coordination, monitoring and evaluation, training and communication. The review drew on the results of over 20 special reviews, studies and evaluations, including the multi-donor evaluation. The findings and recommendations of the multi-donor evaluation for Indonesia included the need (a) to carry out more local-level work; (b) to target increasingly the most needy; (c) to improve the quality and relevance of training; (d) to develop clearer links between decentralized planning, decision-making and fund-raising; and (e) to ensure greater consistency across sectors and programmes in the capacity-building approach.

25. An assessment of training carried out for the mid-term review revealed considerable overlap and duplication between the many training packages produced centrally for implementation at district and lower levels. The review concluded that mechanisms for coordination and convergence should be improved, and recommended that district-level planning bodies should be strengthened so as to provide more effective support for decentralized basic services. The review also concluded that training activities needed to be decentralized and consolidated at the district level.

26. A major conclusion of the mid-term review was that ongoing, sustainable improvement in social development, including achieving the goals of the World Summit for Children, will depend on continuous and innovative refinement and adaptation of centrally developed approaches to suit the varying local conditions of Indonesia's 27 provinces. For example, education on exclusive breast-feeding will require a different approach in a Hindu community in Bali than in a Muslim community in Aceh.

27. Many of the problems identified in the mid-term review are being addressed. The process of decentralization has accelerated since 1992, when the Ministry of Home Affairs regulated the 1974 law on decentralization. In the new regulations, the responsibility of district and municipal governments for many basic services, including health, water supply and sanitation, has been emphasized. The Ministry of Health has decentralized the management of its basic health services to the district level as part of Repelita VI. In selected areas for which UNICEF provides assistance, integrated budgeting and planning mechanisms have been strengthened so that integrated cross-sectoral district plans and budgets for the delivery of basic services are formulated yearly by local area planning offices. Mechanisms for "bottom-up" planning, from village to subdistrict levels, were strengthened to improve the quality of those plans. Experiences to date with this approach has shown significant increases in government funding of activities through central, provincial and district-level budgetary allocations.

28. Urban activities in many different government programmes were consolidated under the area-based approach during the programme period. With the shift towards strengthening the capacity of local governments to develop integrated, area-specific plans for CSD, the differentiation of UNICEF support to rural and urban approaches is no longer appropriate.

29. In order to synchronize the UNICEF programme with Repelita VI, which was launched in April 1994, the Government has requested that the proposed programme of cooperation begin in 1995.

RECOMMENDED PROGRAMME COOPERATION, 1995-2000

General resources: \$72,000,000
Supplementary funds: \$70,000,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Health	16 410	32 440	48 850
Household food security and nutrition	8 985	5 490	14 475
Water supply and sanitation	10 300	12 250	22 550
Planning and social statistics	4 490	-	4 490
Social mobilization and advocacy	5 960	5 400	11 360
Women and children in especially difficult circumstances	2 220	1 870	4 090
Community organization and development	20 275	12 550	32 825
Programme support	<u>3 360</u>	<u>-</u>	<u>3 360</u>
Total	<u>72 000</u>	<u>70 000</u>	<u>142 000</u>

a/ The breakdown for estimated expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Country programme preparation process

30. The proposed country programme for the period mid-1995-2000 is the product of a process coordinated by the National Planning Agency which began in November 1992 with the mid-term review of the 1990-1995 programme. This was followed in November 1993 by a meeting of all government sectors participating in UNICEF cooperation which reviewed the situation analysis and agreed on a strategy for achieving the priority goals and objectives for the period mid-1995-2000. Other United Nations agencies and bilateral donors participated in this meeting. A third meeting with senior officials in February 1994 reviewed the strategy and draft project outlines of the new country programme in conjunction with a draft of Repelita VI. In May 1994, the task forces met for the fourth time to review draft project plans of action and to articulate the

linkages between projects. The UNICEF programme of cooperation is timed to begin one year after Repelita so that UNICEF support to Repelita programmes and targets can best be identified. The timing of the cooperation is also synchronized with the programme cycles of the United Nations Development Programme (UNDP) and the United Nations Population Fund (UNFPA).

31. The basic principles guiding the task forces emphasized the government programmes for achieving goals and targets of Repelita VI and the request that UNICEF assist government programmes to be more effective at the local level. Direct UNICEF support for service coverage is to be decreased in favour of advocacy, capacity-building and innovation within government programmes so as to facilitate their improvement and adaptation to local conditions. Large-scale coverage is to be achieved either through regular government budgets or with the assistance of other donors.

32. With the achievement of the goals for education in Indonesia, it was agreed that support to education programmes should focus on the society-wide dissemination of basic life skills, and that the development of innovative, targeted approaches for reaching illiterate women through the non-formal education programme should become part of the community capacity-building effort, through the provision of support to that component of the country programme. In view of the funding available from the World Bank for primary education, UNICEF will continue to work closely with the Government, the World Bank and the United Nations Educational, Scientific and Cultural Organization (UNESCO) to address issues of quality in formal primary education while concentrating on extending basic schooling from six to nine years.

Country programme objectives

33. The 1992 mid-term review, other assessments and the 1994 situation analysis of women and children suggest that UNICEF assistance can play a major catalytic role in Indonesia's achievement of the goals of the World Summit for Children, which are included in Repelita VI.

34. In Repelita VI, priority targets include the reduction of (a) MMR from 425 to 225 per 100,000 live births; (b) IMR from 58 to 50 per 1,000 live births; (c) U5MR from 81 to 66 per 1,000 live births; and (d) child malnutrition from 40 to 30 per cent. An analysis of the present situation and current rates of improvement suggest that achieving the goals for maternal mortality and child malnutrition will require more support than those for child mortality. Achieving the former would contribute strongly to further reductions in child mortality.

35. As UNICEF resources are limited, priority will be given to supporting achievement of the targets for maternal mortality and child malnutrition specified in Repelita VI. Programmes that focus on several crucial intermediate goals and provide a high degree of leverage for achieving the maternal mortality and child malnutrition targets are an important part of this emphasis. The objectives of the country programme are to achieve and sustain such high-leverage targets as the virtual elimination of micronutrient deficiencies, including achievement of the mid-decade goal for universal salt iodization and the reduction of iron deficiency in pregnant women from 64 to 40 per cent;

increasing coverage for clean water supply from 63 to 80 per cent and of sanitary human excreta disposal from 52 to 80 per cent; increasing antenatal care coverage to 90 per cent; providing emergency obstetric care at all district hospitals; and universal growth promotion through proper infant feeding practices, including achieving the mid-decade goal of implementing the Baby-Friendly Hospital Initiative in the remaining 187 major hospitals.

36. While direct UNICEF assistance will be concentrated in relatively few poor villages, mobilization of additional resources will be attempted as part of the programme of cooperation. Reducing MMR will be central to the development of safe motherhood plans for all districts in the provinces selected to receive more intensive UNICEF support.

37. The progressive implementation of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women are important objectives of the country programme, providing the framework for advocacy for all programme activities.

Programme strategies

38. The creation of local government capacity to adapt existing national service delivery packages to local needs is the central strategic element of the country programme. Achieving the priority targets of Repelita VI will depend on improved district-level capability to assess, analyse and develop actions that will permit goal achievement with resources that either exist nationally or can be mobilized at the district level. UNICEF assistance will help to strengthen social sector planning capacities at the local level for the measurable achievement of goals that are consistent with those of the World Summit for Children. This will be accomplished in part through a tripartite project in which UNICEF and UNDP will work with the Government to develop district plans of action.

39. Four interlinked priority themes of Repelita VI - human resource development, poverty alleviation, decentralization and the integration of women in development - provide important opportunities for UNICEF assistance. Repelita VI emphasizes reducing poverty from 15 to 6 per cent of the population by 1999 through a programme that targets villages that have been "left behind" and provides funds directly to villages for income-generating activities. Achieving priority human resource development targets will require that basic social services reach the poorest of the poor, especially women and children. A priority concern for UNICEF assistance will be to improve the delivery of better targeted, community-based integrated services through posyandus. Promoting the role of women in the management of community health and nutrition activities through the Family Welfare Movement is a unique indigenous community empowerment strategy. The Government will place a trained midwife in each village by the end of the Repelita VI planning period (1999). Linking midwives to the posyandu system should contribute to the improvement of maternal health.

40. In order to improve programme coordination and integration, an operational framework was developed which reflects basic, underlying and immediate causes of maternal and child malnutrition and mortality. UNICEF projects which assist

government programmes are grouped into the following three mutually supportive strategy components:

(a) The first component, which emphasizes service delivery, groups together activities aimed at what needs to be done to resolve the underlying causes of malnutrition and mortality through Repelita programmes for improving household food security and health service delivery. The projects aim to ensure that government staff at district and subdistrict levels are able to deliver improved quality technical services through the extensive health, nutrition and water supply and sanitation service delivery networks;

(b) The second component concentrates on local government and community capacity-building and comprises activities aimed at resolving the underlying causes of malnutrition and mortality as related to improved caring practices for women and children in the community. How to achieve the goals will vary by locality and culture. The health, nutrition and water supply and sanitation services to be utilized by families, women and children must be made available physically and acceptable culturally. This component will develop local plans to ensure wide coverage through the service delivery component. Achievement of many of the priority human resource development targets will depend on communities and families changing their patterns of caring for women and children. The component works through local government, community, religious and educational channels to ensure that basic services reach and can be utilized by the poorest women and children, and will strengthen the capacity of women's organizations to participate in a "bottom-up" planning process with increasing gender sensitivity;

(c) The advocacy and social mobilization component comprises support activities directed at the processes which determine many of the more basic causes of maternal mortality and child malnutrition. This component aims to increase national understanding of the issues underlying maternal and child survival, development and protection and to build societal commitments to address basic and underlying problems. Changing the behaviour of families and communities will require reinforcement and validation at all levels of society. This component will help to disseminate information and mobilize public opinion to help achieve the targets for the reduction of maternal mortality and child malnutrition.

Coverage

41. The three components will have different levels of national and subnational coverage. The advocacy and social mobilization component will cover all of Indonesia's 27 provinces. The components oriented towards service delivery and capacity-building of local governments and communities will provide more intensive direct support in nine selected provinces containing 65 per cent of the total population. Criteria for choosing those provinces included the number of villages "left behind", the status of the priority targets found in Repelita VI and the potential for collaboration with other agencies, including the World Bank and the Asian Development Bank. In each province, all districts will be covered, as will 50 per cent of subdistricts within each district. Within those subdistricts, which will have the highest ratio of "left behind" villages, 50 per cent of such villages will be covered. There will be

progressive coverage of villages, subdistricts and districts; not all will be covered in any one year and the rate of progression will vary by province, depending on local government capacity and the availability of funds.

The country programme of cooperation

42. Within the context of decentralization and local government capacity-building, the area-based approach to planning and managing activities related to the increased survival, development and protection of women and children is the corner-stone of the country programme. An important feature of this process is the Government's "bottom-up" planning system, which provides early identification of activities to be undertaken and commits the Government, UNICEF and other partners to those interventions. This joint planning and budgeting system will be strengthened further and improved in the period mid-1995-2000 by establishing district plans of action in the nine selected provinces for achieving the human resource development targets specified in Repelita VI.

Health

43. UNICEF assistance to government health programmes will prioritize strengthening maternal and neonatal health care within the primary health care (PHC) system.

44. Assistance to the MCH programme aims to increase coverage for antenatal care to 90 per cent and for medically assisted deliveries to 55 per cent. MCH services include support for nutrition and immunization. In collaboration with WHO, the project will strengthen MCH programme management, monitoring and evaluation; improve access to referral services; improve the quality of neonatal services; support activities for the elimination of neonatal tetanus; provide on-the-job training of health centre doctors and community midwives; promote a "mother-friendly" hospital concept; and provide supplies and equipment for midwives. Supplementary funds will be used to increase UNICEF assistance at the subdistrict level and to increase staff presence in the field.

45. UNICEF assistance to the expanded programme on immunization (EPI), provided in collaboration with WHO and Rotary International, will help to maintain high coverage levels and reach the targets for the elimination of poliomyelitis and neonatal tetanus and for measles control. Programme management and disease surveillance will be strengthened. During the course of the collaboration, general resources funding for EPI for the provision of such supplies as sterilizers will be reduced. Substantial amounts of supplementary funds will be required to provide the extra vaccines needed for special national immunization weeks aimed at eradicating poliomyelitis and increasing protection against measles and tetanus.

46. Support to the ARI and CDD programmes will aim to help achieve disease control targets through improving the capacity of health facilities to provide correct case management. Assistance provided in collaboration with WHO will strengthen the supply and logistic system for ORS and antibiotics; strengthen provincial and district planning capacities; strengthen management, training and monitoring activities; and supply timers for monitoring respiration.

Supplementary funds will be used to increase the number of subdistricts receiving direct UNICEF assistance.

Household food security and nutrition

47. UNICEF support to government nutrition programmes will help to reduce the percentage of women and children with inadequate intakes of essential micronutrients and to improve feeding practices of women, children and infants.

48. Assistance to the family nutrition improvement programme will contribute to the reduction of malnutrition by improving maternal and infant feeding practices. UNICEF will provide programme management support; strengthen surveillance; study maternal and infant feeding practices; develop approaches for area-specific improvements of weaning practices; develop participatory training material for health staff to provide improved counselling and guidance through posyandus; monitor the code on the marketing of breast-milk substitutes; and disseminate the "10 steps" for proper breast-feeding to all midwives. During 1995, continued support will be provided in collaboration with WHO to reach the mid-decade Baby-Friendly Hospital Initiative goal.

49. Assistance to the Ministry of Agriculture's food diversification programme will contribute to the reduction of malnutrition by increasing household food security for energy and micronutrients in the "left behind" villages. UNICEF will provide orientation guidelines and management support, improve training and strengthen surveillance and monitoring for agricultural field workers who provide technical support to women farmers' groups. UNICEF assistance for this project is modest, but sufficient to complement the resources available through the government programme.

50. UNICEF support for government food fortification programmes will contribute to reaching micronutrient targets, especially for iodine and iron. Assistance will be provided to the Ministry of Industry and other members of the national salt iodization team to achieve the mid-decade goal of universal salt iodization. Other activities will promote consumer demand for iodized salt, strengthen the capacity of the food industry to produce iodized salt and to regulate itself, and strengthen government and consumer capacity to regulate and monitor salt iodine levels. Subsequently, the Government will receive assistance in fortifying foods with other nutrients, including iron and vitamin A. A marketing approach will be promoted, and the private sector will be encouraged to provide solutions. Supplementary funds will be used to expand the extent of innovative trials in the field and to provide more staff support.

Water supply and sanitation

51. In the area of water supply and environmental sanitation, UNICEF will assist the Ministries of Health, Public Works and Home Affairs to promote the community-based construction of facilities by families through the provision of loans, stimulant funds and technical support at the village level. The project will support programme management, training of sanitarians, strengthening of monitoring systems and provision of moulds and other necessary supplies. Because implementation is to be at the family level, the largest part of the budget is for the provision of stimulant funds and moulds for the construction

of sanitation facilities. Considerable amounts of supplementary funds will be required to help generate district funds and to provide universal coverage of water supply and sanitation in the nine selected provinces. Coordination with the World Bank and WHO will take place through existing inter-agency forums.

Planning and social statistics

52. Support for monitoring the goals of all government programmes will be provided through this project. Under the coordination of the National Planning Agency, together with the Minister Coordinator for People's Welfare, the Central Bureau of Statistics and sectoral monitoring and surveillance systems will be assisted to reach consensus on indicators and a conceptual framework and to establish a cross-sectoral data bank. Relevant programme information obtained from intersectoral analysis will be disseminated to all districts to help them develop district human resource development plans. Assistance also will be provided to improve government programmes through a better understanding of the factors behind behavioural patterns which affect the survival, development and protection of women and children.

Social mobilization and advocacy

53. In an effort to increase coordination of programme activities, all UNICEF advocacy and social mobilization support to government programmes will be provided through this project and coordinated by the Office of the Minister Coordinator for People's Welfare and the Office of the State Minister for the Role of Women. The project aims to raise awareness of the implementation of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Assistance for social mobilization will support the dissemination of information through networks of non-governmental organizations, including through the Ministry of Religious Affairs to the child survival project, through the Ministry of Education to primary schoolteachers, through the Family Welfare Movement to its female village volunteers and through collaboration with the communications channels of the sectoral ministries. Supplementary funds will be channelled to NGOs through the child survival project to promote safe motherhood and CSD.

Women and children in especially difficult circumstances

54. Improving understanding of issues related to the protection of women and children in especially difficult circumstances, as well as support for those women and children, will require increasing attention. Although family and community safety nets are traditionally strong in Indonesia, the growing influence of the media, urbanization and reduced family sizes increasingly are threatening these cultural values. Support will be provided through the Ministry of Social Affairs, the Office of the Minister Coordinator for People's Welfare and the Office of the State Minister for the Role of Women to encourage the development of both governmental and non-governmental experience in this area. Activities will concentrate on operational research, policy development and advocacy and support for the development of innovative approaches. Supplementary funds will permit increased geographic coverage of such activities.

Community organization and development

55. The enhancement of community participation in efforts to reduce maternal mortality and child malnutrition will be approached in a variety of ways. The "bottom-up" planning process will be strengthened to improve the conditions of women and children in the poorest communities. Village councils will be encouraged to take more responsibility for PHC activities, including the guaranteed referral of high-risk pregnant women.

56. Working through the area development programme of the Ministry of Home Affairs, assistance will support the development of goal-oriented district plans, guidelines for "bottom-up" planning, integrated training packages, district profiles and periodic reviews of district and provincial progress towards priority targets. An important effort will be the development of district training and communications activities, which will permit communication strategies to be developed by taking into account different languages, cultural diversity and indigenous channels of communication.

57. Support to the village development programme of the Ministry of Home Affairs will aim to strengthen and improve the management and delivery of basic services for women and children at the subdistrict level and below, especially through the integrated management of and support to posyandus. Priorities will include improving the knowledge and skills of subdistrict government staff and village leaders, especially on matters concerning the care of women and children, gender issues and the strengthening of integrated planning and supervision mechanisms. The local area monitoring system developed previously will be incorporated into this work. UNICEF will assist integrated training, the development of integrated supervision, monitoring and periodic reviews to develop further and spread such approaches. Links to the "left behind" villages of the poverty reduction programme will be cemented through these activities. Supplementary funds will be used to cover more subdistricts and to increase staff support at the field level.

58. Community capacity-building will strengthen community organizations, especially women's, allowing them to participate in village development activities linked to priority goals. Assistance will be provided through the village development programme of the Ministry of Home Affairs, in collaboration with the Family Welfare Movement, the non-formal education programme, the child survival project (with religious non-governmental organizations) and the Social Welfare Department. UNICEF will assist the development of innovative approaches to strengthen community participation in village councils and the posyandu system. The programme will aim to develop ways of linking activities for literacy, income generation and water supply and sanitation in "left behind" villages. Supplementary funds will be used to increase the number of villages receiving direct UNICEF assistance and staff support at the field level.

Monitoring and evaluation

59. UNICEF will assist the Government to monitor relevant indicators for the targets specified in Repelita VI. Improved monitoring by implementing agencies, local governments and communities will continue to be a high priority both for individual projects and for the country programme as a whole. Strong and

effective monitoring will help to improve management, including the operation and maintenance of facilities and services, and help to ensure their sustainability. In addition, more effective evaluation of projects will be facilitated by incorporating appropriate indicators in data-recording and reporting systems. Monitoring and evaluation of periodic achievement and for accountability at the district level and above will be provided largely by the national household socio-economic survey. Support will be provided for the decentralized analysis of data to compile comprehensive, area-specific and issue-focused analyses of the situation of children and women. For the purpose of management at the district level and below, local area monitoring and integrated village needs assessments will be developed further and expanded.

60. Progress towards the achievement of government targets and the impact on the target groups will be evaluated through intensive quantitative monitoring of 100 sentinel communities. One half of these villages are in selected provinces and will become priority sites for intensive behavioural studies on issues related to the survival, development and protection of women and children.

Programme management

61. The National Planning Agency is responsible for the coordination of UNICEF support to the government development plan and budget, with the assistance provided by other donors. This agency is the principal point of contact between UNICEF and the Government and executes formal agreements, chairs the annual review meetings and determines the government's development budgets as counterpart funding.

62. The integration of activities across projects within the country programme and the increased emphasis on local capacity-building, monitoring, evaluation, advocacy and social mobilization require increased levels of management and professional oversight and input. The four existing provincial sub-offices, each staffed by a single Professional for liaison purposes, are well placed to perform those functions. They will be increased in number in proportion to the supplementary funding received for other provinces.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Indonesia		(1992 and earlier years)		UNICEF country classification	
Under-five mortality rate		111	(1993)	High USMR	
Infant mortality rate		71	(1993)	High IMR	
GNP per capita	\$	670	(1992)	Low-income GNP	
Total population		194.6 million	(1993)		
KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1993
Births	(thousands)	4893	5088	5093	5149
Infant deaths (under 1)	(thousands)	516	407	360	366
Under-five deaths	(thousands)	856	649	564	572
Under-five mortality rate (per 1,000 live births)		175	128	111	111
Infant mortality rate (under 1) (per 1,000 live births)		106	80	71	71
		About 1980	Most recent		
Underweight children (under 5)	Moderate & severe	..	40		
(% weight for age, 1987)	Severe	..	..		
Babies with low birth weight (%, 1980)		14	..		
Primary school children reaching grade 5 (%, 1980/1989)		76	83		
NUTRITION INDICATORS		About 1980	Most recent		
Exclusive breast-feeding rate (<4 mos.) (%, 1991)		..	53		
Timely complementary feeding rate (6-9 mos.) (%, 1991)		..	76		
Continued breast-feeding rate (20-23 mos.) (%, 1987)		..	62		
Prevalence of wasting (0-59 mos.) (%)		..	..		
Prevalence of stunting (0-59 mos.) (%)		..	..		
Daily per capita calorie supply (% of requirements, 1979-1981/1988-1990)		113	121		
Total goitre rate (1988)		..	28		
Household expenditure (% of total income, 1980-1985)	All food/cereals	..	48 / 21		
HEALTH INDICATORS		About 1980	Most recent		
ORT use rate (%, 1986/1993)		20	78		
Access to health services	Total	..	80		
(% of population, 1985)	Urban/rural	.. / ..	.. / ..		
Access to safe water	Total	42	63		
(% of population, 1980/1993)	Urban/rural	59 / 37	84 / 53		
Access to adequate sanitation	Total	52	52		
(% of population, 1980/1993)	Urban/rural	77 / 46	78 / 39		
Births attended by trained personnel (%, 1991)		..	32		
Maternal mortality rate (per 100,000 live births, 1986)		..	450		
Immunization		1981	1985	1990	1993
One-year-olds (%) immunized against:	Tuberculosis	55	68	93	94
	DPT	1	16	87	89
	Polio	1	14	91	93
	Measles	..	47	..	90
Pregnant women (%) immunized against:	Tetanus	10	26	54	67

Indonesia

EDUCATION INDICATORS		About 1980		Most recent		
Primary enrolment ratio (gross/net) (%, 1980/1989)	Total	107	/ 88	116	/ 98	
	Male	115	/ 93	119	/ 100	
	Female	100	/ 83	114	/ 96	
Secondary enrolment ratio (gross/net) (%, 1980/1989)	Total	29	/ ..	45	/ 38	
	Male	35	/ ..	49	/ 41	
	Female	23	/ ..	41	/ 36	
Adult literacy rate, 15 years & older (%, 1980/1990)	Total	67		84		
	Male/female	77	/ 58	88	/ 75	
Radio/television sets (per 1,000 population, 1980/1991)		99	/ 20	146	/ 59	
DEMOGRAPHIC INDICATORS		1970	1980	1990	1993	2000
Total population	(thousands)	120280	150958	184283	194617	217998
Population aged 0-15 years	(thousands)	53455	65249	69969	70857	72463
Population aged 0-4 years	(thousands)	19901	22374	22791	23295	23116
Urban population (% of total)		17.1	22.2	28.8	31.1	36.5
Life expectancy at birth (years)	Total	48	54	61	63	66
	Male	47	53	60	61	64
	Female	49	56	63	65	68
Total fertility rate		5.3	4.4	3.3	3.1	2.5
Crude birth rate (per 1,000 population)		40	34	28	26	22
Crude death rate (per 1,000 population)		18	13	9	8	7
		About 1980		Most recent		
Contraceptive prevalence rate (%, 1991)		..		50		
Population annual growth rate (%, 1965-1980/1980-1993)	Total	2.3		2.0		
	Urban	4.6		4.5		
ECONOMIC INDICATORS		About 1980		Most recent		
GNP per capita annual growth rate (%, 1965-1980/1980-1992)		5.2		4.0		
Inflation rate (%, 1970-1980/1980-1992)		22		8		
Population in absolute poverty (%, 1987)	Urban/rural	.. / ..		20 / 16		
Household income share (%, 1990)	Top 20%/bottom 40%	.. / ..		42 / 21		
Government expenditure (% of total expenditure)	Health/education	.. / ..		2 / 9		
	Defence	..		8		
Household expenditure (% share of total, 1980 or 1985)	Health/education	.. / ..		2 / 4		
Official development assistance: (1981/1992)	\$US millions	975		2080		
	As % of GNP	1		2		
Debt service (% of goods and services exports, 1982/1992)		11		20		

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1990-1994 ^{a/}

COUNTRY: INDONESIA
LATEST BOARD APPROVAL: 1990
GENERAL RESOURCES: \$62 450 000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		General resources		TOTAL SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	5 798	6 711	1 866		805		4 521	131	12 990	16 501	6 842	4 495	19 832	20 996
Nutrition	2 845	5 485	2 134	1 491	698		2 561	1 397	8 238	11 471	8 373	16 175	16 611	27 646
Water supply and sanitation	1 803	517	547	30	1 619		3 473	1 040	7 442	10 780	1 587	8 500	9 029	19 280
Education	35		617		189		2 631		3 472	5 409			3 472	5 409
Community organization and development										6 707				6 707
Advocacy	124	222	1 620	266	154		3 794	1 079	5 692	5 712	1 568	3 030	7 260	8 742
Planning and social statistics	172	32	1 178	64	984		3 223	743	5 557		839		6 396	
Programme support	378		9		1 777		2 500	29	4 664	1 320	29		4 693	1 320
Unallocated reserve										4 550				4 550
GRAND TOTAL	11 155	12 967	7 971	1 851	6 226	1	22 703	4 419	48 067 ^{b/}	62 450	19 238	32 200 ^{c/}	67 293	94 650

GR = General resources.

FSF = Programmes approved for funded supplementary funding.

SF = Programmes for supplementary funding, funded and unfunded.

^{a/} Actual expenditures include expenditures recorded as of November 1994.

^{b/} Including expenditures from global fund and additional allocation of general resources for unfunded programmes for supplementary funding.

^{c/} Of this amount, \$24 549 421 remains unfunded.

TABLE 3. PLANNED EXPENDITURE, 1995 - 2000

(In thousands of United States dollars)

Country: INDONESIA Period covered: 1995 - 2000		Funding status	1995	1996	1997	1998	1999	2000	Total
Health	GR		2 640	2 640	2 845	2 705	2 760	2 820	16 410
	FSF		1 367						1 367
	NSF		6 850	6 850	9 950	4 600	2 600	1 590	32 440
Household food security and nutrition	GR		1 640	1 640	1 595	1 570	1 345	1 195	8 985
	NSF		550	690	750	1 000	1 200	1 300	5 490
Water supply and sanitation	GR		1 820	1 820	1 640	1 640	1 640	1 740	10 300
	NSF		1 650	1 860	2 000	2 130	2 200	2 410	12 250
Community organization and development	GR		3 230	3 230	3 295	3 410	3 530	3 580	20 275
	NSF		1 450	1 750	2 100	2 850	2 400	2 000	12 550
Women and children in especially difficult circumstances	GR		360	360	345	345	395	415	2 220
	NSF		150	150	300	520	450	300	1 870
Social mobilization and advocacy	GR		1 020	1 020	980	980	1 030	930	5 960
	NSF		350	700	900	900	1 150	1 400	5 400
Planning and social statistics	GR		730	730	740	790	740	760	4 490
Programme support	GR		560	560	560	560	560	560	3 360
TOTAL	GR		12 000	12 000	12 000	12 000	12 000	12 000	72 000
	FSF		1 367						1 367
	NSF		11 000	12 000	16 000	12 000	10 000	9 000	70 000
GRAND TOTAL			24 367	24 000	28 000	24 000	22 000	21 000	143 367

GR = General resources.

FSF = Programmes approved for funded supplementary funding.

NSF = New programmes for supplementary funding.



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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Myanmar

SUMMARY

The Executive Director recommends that the Executive Board approve:

(a) The country programme of Myanmar for the period from 1996 to 2000 in the amount of \$32,500,000 from general resources, subject to the availability of funds, and \$23,500,000 in supplementary funds, subject to the availability of specific-purpose contributions;

(b) Additional general resources in the amount of \$3,230,000 to fund the approved country programme for the period from 1991 to 1995 for which the balance of approved general resources is not sufficient to fund the programme up to the approved programme period.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

CONTENTS

	<u>Page</u>
I. THE SITUATION OF CHILDREN AND WOMEN	3
II. PROGRAMME COOPERATION, 1991-1995	5
III. RECOMMENDATION FOR ADDITIONAL GENERAL RESOURCES FOR THE APPROVED COUNTRY PROGRAMME, 1991-1995	8
IV. RECOMMENDED PROGRAMME COOPERATION, 1996-2000	10

List of tables

1. Basic statistics on children and women	19
2. Expenditure under the previous cooperation period, 1991-1995	21
3. Planned expenditure, 1996-2000	22

I. THE SITUATION OF CHILDREN AND WOMEN

1. Myanmar is a least developed country with per capita gross national product (GNP) of about \$220. Since 1989, the country has moved gradually towards an open market economy, with reported foreign investments of \$707 million in 1993-1994 and a GNP growth rate of 6 per cent in 1993. That investment has initially been concentrated in the tourism and consumer product sectors. The population of 44 million is estimated to be growing at an annual rate of 1.8 per cent; 72 per cent of the population live in the seven divisions of the country where communications and public services are relatively more advanced, with the remaining 28 per cent living in the seven ethnic minority states.

2. Because there is a shortage of social and economic data on Myanmar, it is often difficult to assess trends over the last decade and analysis must sometimes be based on field observations alone. Until 1991, the infant mortality rate (IMR) and under-five mortality rate (U5MR) were assessed officially at 47 and 91 per 1,000 live births, respectively. However, after a reassessment of available data, IMR was readjusted to 94 and U5MR to 147 per 1,000 live births. In terms of disparity, IMR is estimated at 27 per 1,000 live births for the capital division of Yangon and well over 100 for three ethnic minority states. Diarrhoeal diseases, respiratory infections and malaria, often compounded by malnutrition, are the major causes of infant and young child deaths. The maternal mortality rate (MMR) is estimated to be 140 per 100,000 live births, with considerable regional disparities. Almost one half of maternal deaths are related to abortion of unwanted pregnancies.

3. About 37 per cent of young children suffer from protein-energy malnutrition (PEM), of whom 11 per cent are severely malnourished. The diets of many children and families are deficient in vitamin A, iron and iodine. Breast-feeding is practised almost universally, although it does not always begin early enough nor is it continued exclusively for four to six months. Inadequate weaning practices and inappropriate weaning foods contribute to young child malnutrition.

4. The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are on the rise, with a potentially disastrous impact on the lives of young people and families. Although only 261 cases of full-blown AIDS and fewer than 7,500 HIV-positive cases had been confirmed by 1993, the World Health Organization (WHO) has estimated that the number of HIV-positive cases could be as high as 500,000. Early studies reveal that young people working as fishermen, truck drivers, traders, day labourers and miners, as well as their wives or partners, are particularly at risk. National plans and programmes on HIV/AIDS control have expanded rapidly since 1993.

5. Myanmar has a widespread primary school network, but in remote areas of the states there are communities without schools. Some 39 per cent of children never enrol in primary school and only 25 per cent complete the five-year cycle. Based on field observations, drop-out rates for girls seem to be somewhat higher in some areas of the country. Repetition rates are also high. There has been relatively little progress in primary enrolment and completion in recent years,

indicating the magnitude of the challenge presented by the goal of education for all.

6. Water-borne diseases such as hepatitis, cholera and other diarrhoeas are prevalent in some areas of the country and account for considerable young child mortality and morbidity. Although the number of families with access to safe water has increased gradually over the last decade, only 39 per cent of the population had access to safe drinking-water and 42 per cent to sanitary latrines in 1993.

7. There are disparities between children in different areas of the country. The overall situation of children in core urban areas tends to be considerably better than in urban resettlement and rural areas. Most indicators of health, nutrition and education suggest that children in the seven central divisions of the country are generally better off than children in the peripheral states, where most ethnic minority groups live. In the most remote border areas, some ethnic communities have had virtually no public services because of armed conflicts and problems of accessibility. Some government services and programmes run by non-governmental organizations began to reach a few of those groups in 1992.

8. Myanmar has made considerable progress towards some of the 12 relevant mid-decade goals for children, but will have difficulty in achieving others because of the lack of a sufficient social service infrastructure and of resources for programme and project development. With the immunization rate at 71 per cent in 1994, the goal of 80 per cent probably will be achieved by the end of 1995 with a major effort in the states. With this progress, the goals for reducing morbidity and mortality due to measles and the elimination of neo-natal tetanus may be achieved within a few years. With less than 20 per cent of salt currently iodized, the goal of universal salt iodization would be extremely difficult to achieve, but some policy focus, support to salt producers and mass education promise success within a few years. Although achieving the mid-decade goals of eliminating vitamin A deficiency and of 80 per cent use of oral rehydration therapy would require tremendous efforts, policy and programme focus on both areas were sharpened during 1994. About one third of Myanmar's children under five years of age suffer from moderate or severe malnutrition. A much sharper policy focus and a national plan will be needed to achieve the malnutrition reduction goal. The country is on schedule to certify all 92 of its major hospitals as "baby-friendly". A major programme is in place to reduce the number of children out of school, but it will not have a full impact on primary school enrolment for several years. Achievement of the goals for the year 2000 will depend on intensified national commitment in such areas as basic education, nutrition and water supply and sanitation. In several cases, indicators will have to be established and monitoring and data systems strengthened to monitor the situation of children and women and progress towards the country's goals.

9. In 1991, Myanmar signed the Declaration and Plan of Action of the World Summit for Children. In September 1993, the National Programme of Action (NPA) for the Survival, Protection and Development of Myanmar's Children in the 1990s was completed. In July 1991, Myanmar acceded to the Convention on the Rights of

the Child, and two years later, the country's Child Law was promulgated. An Intersectoral Committee on the Rights of the Child has been formed.

10. In moving beyond its traditional support to service delivery, UNICEF directly advocated Myanmar's signature of the World Summit Declaration and accession to the Convention on the Rights of the Child, and also encouraged review and reporting on implementation of the Convention. UNICEF has encouraged the emerging group of both national and international non-governmental organizations to focus on the basic health, nutrition and welfare needs of families and children; advocated and supported the work of international non-governmental organizations in the country; and supported capacity-building for national non-governmental organizations so that they could become knowledge and action centres for children in Myanmar. UNICEF also has participated in a number of United Nations inter-agency initiatives in such areas as water supply, sanitation, nutrition and HIV/AIDS.

II. PROGRAMME COOPERATION, 1991-1995

11. UNICEF assistance to the children and women of Myanmar has continued uninterrupted for more than four decades, despite changing political and economic circumstances. UNICEF assistance has included support for the development of local capacities to provide maternal and child health services. UNICEF has become an advocate for the nation's children, encouraging policies that empower communities and families with the information they need for the survival and development of their children. UNICEF cooperates with a number of national and international non-governmental organizations in the areas of service delivery, advocacy, community awareness and local capacity-building. Such key national non-governmental organizations as the Myanmar Maternal and Child Welfare Association, the Myanmar Medical Association and the Myanmar Red Cross have been responsive to those concerns.

12. The elaboration of specific, time-bound goals in the NPA has provided a sharper focus for the current programme of cooperation. The goals corresponded closely with the 17 objectives of the 1991-1995 country programme of cooperation, which addressed infant, under-five and maternal mortality; PEM; access to safe water supplies and sanitary latrines; primary school enrolment and school drop-outs; and access to services for young children. The country programme has emphasized universal coverage and disparity reduction.

Health

13. UNICEF cooperation has served as a catalyst to help increase immunization coverage from 68 per cent in 1990 to 71 per cent in 1994. Until 1992, the immunization programme was operational in 209 out of 320 townships in the country, covering 80 per cent of the population. In 1993 and 1994, attempts were made not only to increase coverage in those 209 townships, but also to increase to 302 the number of townships with immunization services. In the additional 93 townships, solar refrigerators were provided to areas without electricity. Immunization activities were launched in newly peaceful areas through training, the provision of cold-chain supplies and bicycle transport. In areas with insufficient rural health staff, services were extended through a

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new category of locally recruited indigenous auxiliary nurse midwives who work in their own areas. With those developments, it is projected that 80 per cent immunization coverage will be achieved by the end of 1995.

14. The child survival project provided training in a range of child survival, health and nutrition skills to some 6,400 midwives, who serve as multi-purpose front-line health workers. The training focused particularly on immunization, diarrhoeal diseases, respiratory infections, growth monitoring and prenatal care.

15. With support primarily from WHO and the United Nations Development Programme (UNDP), a national HIV/AIDS control programme was developed in 1992. To address the growing HIV/AIDS problem, a new project providing reproductive health education for youth and women was initiated with support from UNICEF global funds late in 1993. The project also strengthens services for the treatment of sexually transmitted diseases. By the end of 1994, it was operating in 15 townships to provide life skills education to an estimated 2,000 young people and women who will serve as peer educators.

Nutrition

16. Growth monitoring of children under three years of age is taking place in 31 per cent of all villages in Myanmar, with increased attention to follow-up action for children with faltering growth.

17. Under the Baby-Friendly Hospital Initiative introduced in 1992, good progress has been made in promoting optimal breast-feeding in terms of early initiation, proper duration and exclusive breast-feeding for the first four to six months. Following technical planning and training sessions with leaders and assessors of pilot hospitals, 45 hospitals had been assessed against international standards and certified "baby-friendly" by the end of 1994. All 92 of the country's major hospitals are targeted for certification by the end of 1995. To promote optimal breast-feeding for the 80 per cent of babies delivered at home, the Baby-Friendly Home Delivery project was launched. Midwives are trained to help mothers understand the benefits of exclusive breast-feeding and to begin breast-feeding immediately after delivery.

18. Myanmar Salt Enterprise has increased the production of iodated salt from 2,500 tons in 1991 to 10,000 tons in 1994. Sixty private producers have been trained in iodation, of which 40 had received equipment and 5 had begun production by the end of 1994. Red Cross volunteers and other non-governmental organization groups began to promote the use of iodated salt in 1994. Despite considerable UNICEF advocacy, legislation on salt iodation was not yet in place by the end of 1994.

Water supply and sanitation

19. Between 1991 and 1994, the water supply and sanitation programme provided approximately 480,000 households with safe drinking-water, benefiting 2.8 million people. Shallow tube wells with hand-pumps were constructed in many areas of lower Myanmar, while deep tube wells were constructed in the area of the country known as the Dry Zone. A number of communities in the Chin and Shan

states were provided with spring-fed, gravity-flow water systems. A total of 293 rural health centres and 444 primary schools were provided with clean water supplies and about 6,300 caretakers and maintenance workers, as well as a number of technicians, were trained.

20. In order to improve household and community sanitation, UNICEF has supported the construction and use of sanitary latrines. This project has involved cooperation between families, who provided labour and local materials, the Department of Health, which provided motivation and technical assistance, and UNICEF, which provided plastic latrine pans. Between 1991 and 1994, 550,000 households constructed sanitary latrines, covering 3.3 million people. Another 2,600 units were constructed in primary schools and rural health centres.

Education

21. The Continuous Assessment and Progressions System (CAPS) project, which introduced a new interactive approach to teaching, was initiated in 1991 in 44 primary schools. CAPS also has trained teachers to assess regularly the learning achievement of children so that they can make continuous progress towards completion of primary education. Based on the initial experiment, the CAPS approach was expanded to cover a total of 3,070 schools and 450,000 children. CAPS has been adopted by the Ministry of Education to replace the prevailing system of rote learning and single, year-end examinations.

22. In 1994, the All Children In School (ACIS) project was started in 1,500 schools in 10 townships. It is directed towards the goal of universal enrolment and aims at orienting and mobilizing teachers, school heads, parent-teacher associations, community leaders and local education officers to bring non-enrolled children into school with regular attendance. CAPS and ACIS are complementary in that ACIS promotes community support to bring all children into school, while CAPS strengthens school management and learning among the children who enter school.

Child rights and children in especially difficult circumstances

23. While there has been some exploratory work in this area, it was not specifically defined at the outset of the country programme. Beginning in 1994, an initial study of street children was undertaken by several non-governmental organizations, as was one on children and women working in the informal sector. The findings will provide the basis for project formulation for the new country programme.

Constraints and lessons learned

24. There have been a number of underlying constraints to the achievement of the mid-decade goals and the objectives of the current country programme. Myanmar has allocated only limited government resources to social sector programmes and there has been virtually no bilateral support for the social sectors during the period. Because both health and education services have functioned for several decades on the principle of free services, the concept of cost-sharing has been slow to take hold at both official and community levels. Finally, many areas of the country, particularly in the states, have been

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inaccessible for service delivery and development because of insecurity and/or lack of roads or other means of transportation.

25. Programme implementation, in terms of activities, inputs, outputs and expenditures, was monitored by UNICEF at the project level virtually month by month. UNICEF staff have visited projects in all states and divisions. Annual and mid-term reviews were held, involving all participating sectors, non-governmental organizations and other United Nations agencies.

26. The exercise of its advocacy role has been particularly challenging for UNICEF in Myanmar. Selectively sharing the experiences of other countries in the region has been helpful in promoting new ideas. The disparity between service delivery in the divisions and the states became evident in such fields as immunization, basic health services and primary education. This recognition has highlighted the need for universal coverage and disparity reduction. In addition, the importance of enhanced community participation in addressing the needs of children and families has been recognized and creative means of reaching out to communities and families had to be explored and tested. The emerging problem of HIV/AIDS will have a major impact on family and child health and welfare in the second half of the present decade. Myanmar's emerging non-governmental organizations have demonstrated their concern for the needs of unserved population groups and a readiness to address them. It is clear that they can play a major role in community-level activities, motivation and mobilization. This experience has been carried forward in developing the new country programme.

III. RECOMMENDATION FOR ADDITIONAL GENERAL RESOURCES FOR THE APPROVED COUNTRY PROGRAMME, 1991-1995

Annual funding requirements

(In thousands of United States dollars)

<u>Current programme cycle</u>	<u>Approved general resources funding a/</u>	<u>Additional funding proposed</u>	
		<u>1995</u>	<u>Total</u>
1991-1995	25 000	3 230	3 230

a/ The amount shown here includes the actual balance carried over from the previous programme cycle.

27. The Myanmar country programme for the period 1991-1995 was approved by the Executive Board in 1991 with an allocation of \$25 million from general resources (E/ICEF/1991/P/L.14). Based on the availability of additional general resources, the reassessment of data on IMR and U5MR and programme needs, the annual planning level has been increased from \$5 million to \$5,500,000 for the period 1992-1994 and to \$6,500,000 for 1995. Additional general resources in

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the amount of \$200,000 were made available during the period to facilitate and accelerate priority activities contributing to the achievement of selected mid-decade goals, including the extension of universal child immunization to border areas, the promotion of the Baby-Friendly Hospital Initiative, early childhood development activities, expansion of water supply and sanitation in deprived areas and the introduction of ACIS. Additional general resources in the amount of \$3,200,000 are being requested for 1995 in order to maintain the annual planning level for Myanmar at \$6,500,000.

28. Following the mid-term review of the current country programme in October 1993, the programme was restructured to achieve selected mid-decade goals. The immunization programme has been expanded to cover all townships in order to achieve 80 per cent coverage throughout the country by the end of 1995. Safe motherhood activities will be intensified in 1995 and closely linked with the neonatal tetanus elimination plan. "User-friendly" clinics, operated by non-governmental organizations in accessible areas to provide HIV/AIDS education and counselling to high-risk groups, will be extended from 15 to 25 townships in 1995. All 92 hospitals will be certified as "baby-friendly" and the Baby-Friendly Home Delivery Programme will be intensified. The empowerment of communities and families will be emphasized in the preventive nutrition, health care and household food security projects.

29. ACIS aims to increase enrolment of out-of-school children and to promote regular attendance and completion in 1,500 primary schools. CAPS will address the problems of high rates of failure, repetition, drop out and low retention in 3,070 rural primary schools. Parent-teacher collaboration, effective teaching and learning methods and learning materials for supervisors, teacher trainers, primary teachers and students will be emphasized.

30. The safe supply water and sanitation programme will intensify actions for changing attitudes and behaviour pertaining to safe water, the disposal of human excreta and personal hygiene. A nationwide survey and inventory of water supply and sanitation facilities will provide baseline data for monitoring progress towards the goals for the year 2000. With priority going to remote and deprived areas in the states, more primary schools and health centres will be provided with safe water and sanitation facilities. Schoolchildren will be motivated to act as agents of change by communicating health messages to their families.

31. The children in an especially difficult circumstances project will focus on drafting a training programme and guidelines on such children; completing studies on street children, working children and working women; and initiating studies of child abuse, juvenile delinquency and rehabilitation and the care of children affected by insurgencies and disabilities. A national workshop will be organized on children in especially difficult circumstances, and key partners will be trained.

32. Advocacy, through meetings, workshops, and publications, will concentrate on strengthening the commitment of decision makers and non-governmental organization leaders to addressing priority problems of children and women and on preparing subnational plans of action for implementation and monitoring of the NPA. Information and communication activities will concentrate on developing field workers' basic communication skills using a participatory

approach. Training and communication materials will support face-to-face communication and mass media for disseminating information on nutrition, oral rehydration therapy, immunization, the use of iodated salt, water supply and sanitation and education.

IV. RECOMMENDED PROGRAMME COOPERATION, 1996-2000

General resources: \$32,500,000

Supplementary funding: \$23,500,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Health	13 000	11 000	24 000
Water supply and sanitation	6 300	7 500	13 800
Education	6 400	5 000	11 400
Children in especially difficult circumstances	1 500	-	1 500
Social mobilization and advocacy	2 150	-	2 150
Planning and social statistics	<u>3 150</u>	<u>-</u>	<u>3 150</u>
Total	<u>32 500</u>	<u>23 500</u>	<u>56 000</u>

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

33. The proposed country programme is based on the Convention of the Rights of the Child and the NPA, as well as on the accumulated experience of cooperation in Myanmar to date as most recently assessed in the mid-term programme review. During the first half of 1994, UNICEF, relevant sectors and non-governmental organizations joined together in workshops on programme strategy and project formulation where the overall content of the country programme was outlined. An advisory committee of distinguished persons from sectors, non-governmental organizations and the United Nations community reviewed the programme's approach and content, and a Myanmar/UNICEF Steering Committee guided the overall work on programme formulation. A preview of the entire draft programme took place in

August 1994 with seven ministries, United Nations agencies, non-governmental organizations and embassy representatives of 14 members of the Executive Board.

National goals for children

34. The NPA goals for the year 2000 are (a) to reduce IMR to not more than 50 per 1,000 live births, USMR to not more than 70 per 1,000 live births and reduce MMR to not more than 70 per 100,000 live births; (b) to achieve and maintain a full immunization coverage rate of over 90 per cent in all states and divisions; (c) to reduce levels of severe and moderate malnutrition in children under three years of age to not more than 5 and 13 per cent, respectively; (d) to eliminate iodine deficiency disorders and vitamin A deficiency; (e) to raise the rate of access to safe drinking-water to 100 per cent and ensure that all households use hygienic latrines; (f) to ensure that 100 per cent of primary-school-age children are enrolled in school and at least 80 per cent of them complete standard four; and (g) to empower parents, families and local communities with the knowledge, attitudes and skills needed to ensure the survival and development of their children, especially in unserved border and other areas.

35. The objectives of the country programme are to advocate on behalf of all children through support for universal coverage, while emphasizing the specific needs of girls and women. It will also aim to strengthen sustainable approaches and to promote convergence among the various programmes, especially to reduce regional disparities in the situation of children and women. Within this framework, each programme specifies the contributions to be made through the programme of cooperation to Myanmar's achievement of its NPA goals by the year 2000.

36. The proposed level of supplementary funds amounts to almost 43 per cent of the proposed programme budget based on programme needs, particularly in the areas of health, water supply and sanitation and education. The degree to which the objectives of the proposed programme of cooperation will be achieved by the year 2000 will depend, to a great extent, on the degree of success in mobilizing national and external resources for the children and women of Myanmar.

Programme strategies

37. UNICEF will continue to intensify its efforts to promote the achievement of the goals of the World Summit for Children and the Convention on the Rights of the Child. Efforts will be made to enhance the capability of sectors and non-governmental organizations as focal points for the implementation of the NPA. UNICEF cooperation will comprise a mixture of the strategies for service delivery, selective capacity-building, particularly among non-governmental organizations, and public services at subnational levels and will encourage and support the empowerment of parents, women, families and communities with the knowledge and skills to address the needs of their children. Many of the following programme strategies complement those of other United Nations agencies working in Myanmar.

Advocacy for children

38. The country programme will advocate the principle of "a first call for children" on a nationwide scale. All parties agree that all possible efforts will be made to apply the maximum possible resources to child survival, development and protection.

Family and community empowerment

39. All projects are designed to have an impact at family and community levels. Child immunization, AIDS education, iodized salt, primary school upgrading and teaching, clean water and improved sanitation are benefits designed to have a direct effect on thousands of communities. Most UNICEF assistance either will reach community and family levels directly or will be designed to facilitate local level capacity-building and implementation. Examples of the latter include surveys for establishing baseline data, training of supervisors and front-line workers, cold-chain inputs, national advocacy and communications campaigns and capacity-building for non-governmental organizations.

Coverage

40. With an emphasis on universal coverage of basic services, combined with disparity reduction, projects such as advocacy, universal child immunization and safe water supply and sanitation will aim for national coverage, while at the same time providing greater support to selected states and townships with the greatest needs and weaker or non-existent service delivery mechanisms. Other projects such as ACIS and CAPS will focus on townships with low primary school enrolment and retention rates. The HIV/AIDS project will focus on 34 new townships in addition to the 25 townships already covered, thus reaching most of the country's urban population.

Constituency for children

41. National and international non-governmental organizations are emerging as major protectors of children in terms of advocacy and the promotion of basic services. Under this country programme, they will play an even greater role in taking knowledge, understanding, skills and inputs to the community level. The building of their capacity is a vital element of the country programme, as is their role in designing and implementing experimental projects to meet the needs of children and communities in diverse geographic and ethnic areas.

Disparity reduction

42. In order to progress towards the goal of universal benefits for all children and women, the country programme will continue to address significant geographic, ethnic, socio-economic and gender disparities. Special attention will be paid to unserved and underserved areas of the states and to the special needs of girls and women.

Communications and social mobilization

43. Successful advocacy and empowerment will rely on carefully planned communications and social mobilization initiatives involving public sector agencies, non-governmental organizations, religious groups, communities and the media. Extensive use will be made of popular video parlours and comic books, peer education and other existing channels of communication.

Building on experience

44. In the areas of immunization, the training of midwives, primary school teaching and rural water supply and sanitation, the aim will be to ensure quality and universal coverage. Work to control HIV/AIDS through reproductive health education, breast-feeding promotion and increasing primary school enrolment will require adaptation and innovation in light of experience to date. UNICEF will continue to advocate increases in national and external resources for human development, especially programmes for children. Initial experiences in communications and social mobilization will be used to support virtually all programmes.

Health

45. A set of 14 health-related goals in the NPA is the foundation for the health programme. Foremost among those goals are those pertaining to the reduction of IMR, USMR and MMR.

46. The health strategy focuses on empowering parents, women, families and communities to take more responsibility for the survival and health of their own children. In order to reach all families in all areas, two new groups will be involved. First, a new category of health workers - auxiliary nurse midwives - will be recruited from the underserved areas to work there. Second, national and international non-governmental organizations will be encouraged to work more effectively at the local level in unserved areas. Their capacities to function as advocates for children and women, as well as to plan, implement and monitor health programmes, will be strengthened through the training of non-governmental organization staff in advocacy, community organization and mobilization, community education and the provision of technical assistance and supplies as appropriate for implementing community-based programmes.

47. The universal child immunization project aims to achieve 90 per cent coverage in every state, division and township by the year 2000. Immunization will be a vehicle for bringing health services to many unserved communities. Social mobilization and immunization days will enhance demand for immunization services. To reach the unserved areas, health staff will be trained and the cold chain will be developed at state and township levels. Non-governmental organizations will participate in promotional activities and directly support service delivery in selected areas where health services are weak. In those areas, health education, using Facts for Life, and iodated salt will be provided together with immunization.

48. Priority support will be provided to reduce young child deaths caused by diarrhoea by 45 per cent and those by acute respiratory infections by

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25 per cent. An 80 per cent oral rehydration therapy use rate will be achieved and sustained. Priority will be given to providing parents with an understanding of the causes of diarrhoea and dehydration and with the skills needed to use oral rehydration therapy. Services for acute respiratory infections will be made available as close as possible to homes and local capacity for timely referral will be developed. Relevant knowledge and skills will be provided by trained midwives, auxiliary nurse midwives and community and non-governmental organization volunteers. Essential drugs will be provided and the involvement of local drug outlets will be sought.

49. The high MMR and other problems relating to women's health will be the focus of a women's health project. The major targets are to achieve 100 per cent access to safe delivery services, improved access to referral services for emergency obstetrical care and universal access to information on birth spacing. Life skills for adolescent girls will be enhanced to help protect their reproductive health and reduce the number of early marriages and teenage pregnancies. This activity will complement the HIV/AIDS prevention project.

50. Health services will be strengthened and families and communities empowered with health knowledge and skills in the border areas of Chin, Kachin, Kayin, Kayah, Mon, Shan and Rakhine states and in Sagaing division. Auxiliary nurse midwives from those areas will be trained. Health education materials in local languages and pictorial materials will be used in areas with high illiteracy rates. Education and other services will be adapted to the major child and family health problems prevailing in project areas. Where they are active, non-governmental organizations such as the Myanmar Maternal and Child Welfare Association and the Kachin Baptist Convention will participate in health education services.

51. The strategy aimed at the prevention of HIV/AIDS transmission will be continued. The diagnosis and treatment of sexually transmitted diseases will be introduced in maternal and child health services and strengthened within existing sexually transmitted disease units in high-risk towns. Local chapters of non-governmental organizations such as the Myanmar Red Cross, the Myanmar Maternal and Child Welfare Association and the Myanmar Medical Association will conduct intensive reproductive health and HIV/AIDS education focused on youth and women. Services will be expanded to cover 103 towns, serving 49 per cent of the country's urban population.

Nutrition

52. The NPA contains seven nutrition goals that are the basis of Myanmar/UNICEF cooperation. The programme's objectives are to reduce the incidence of severe and moderate malnutrition among children under three years of age; to reduce the rate of low-birth-weight babies; to virtually eliminate iodine and vitamin A deficiencies; and to enhance further optimal breast-feeding practices. Those objectives depend on actions at the household level involving food, health and care and will be supported by such cross-sectoral activities as the control of diarrhoeal diseases and acute respiratory infection, women's health, environmental sanitation, primary education and programme communications.

53. Both empowerment of families with knowledge and skills and community mobilization will be central to the overall nutrition strategy. For example, family food production, dietary diversification and the dissemination of practical information on balanced diets and local food resources will be promoted through home, community and school gardens. Non-governmental organizations such as the Myanmar Red Cross will play an active role, particularly in promoting and monitoring the availability and use of iodated salt. UNICEF will support surveys and provide training costs, as well as garden tools, seeds, education and information materials, scales for growth monitoring, potassium iodate and vitamin A and iron supplements.

Water supply and sanitation

54. Within the framework of the NPA goals of universal access to safe drinking-water and safe means of disposal of human excreta, the objectives of the programme will be to increase safe water coverage from 43 to 81 per cent and sanitation coverage from 45 to 80 per cent.

55. Because of the scope of progress required, the strategy calls for cost-sharing with communities, participating agencies and donors. A community self-help approach will be complemented by further involvement of non-governmental organizations and the private sector in providing safe water. Awareness of and demand for improved water supply and sanitation will be stimulated through a nationwide community education and mobilization initiative. Increased participation by women in project planning, implementation, operation and maintenance will be sought. Full achievement of the goals will require major inputs in the form of national budgetary allocations, UNICEF supplementary funding and other external assistance. As part of a United Nations inter-agency group on water supply and sanitation, UNICEF will continue to support policy development and the strengthening of institutional structures for the sector.

56. UNICEF will assist with the construction of 57,900 shallow and 4,600 deep tube wells as well as gravity-flow, irrigation dam and rainwater schemes in communities. In addition, 5,800 primary schools and rural health units will be served and 12,000 additional hand-pump caretakers will be trained. UNICEF inputs will include pipes, fittings, hand-pumps, materials for local hand-pump manufacture, training materials and technical assistance.

57. The major effort in the area of environmental sanitation will be long-term, nationwide support to communication, education and motivation for hygiene and sanitation. Based on a 1992 sanitation study and the communication strategy formulated in 1993, a few simple messages on hygiene and sanitation will be disseminated through all relevant channels, including schoolteachers, health workers, non-governmental organizations, radio, television and video. The aim will be to motivate families to improve hygiene and sanitation practices, and the programme will include the construction of 3.2 million household latrines. UNICEF will provide 252,000 plastic latrine pans for poor, underserved communities in the states, while other communities will pay for pans to encourage a self-help approach. The programme will rely on a self-learning package and inputs from local leaders, families, communities and non-governmental organizations.

Education

58. Within the framework of the NPA goals of universal access to basic education and 80 per cent completion of primary education, the objectives of the proposed programme are to cover all children through the ACIS project and 7,500, or 21 per cent of rural schools, through the CAPS project.

59. The ACIS project will promote increased enrolment at the village level through teachers, parent-teacher associations, community leaders and assistant township education officers. Their efforts will be complemented by a national school enrolment mobilization campaign, a part of which will be to establish individual school and township enrolment targets. Schools will be offered incentives to achieve those targets, including new roofing, improved water supply and sanitation, basic teaching kits and teaching aids.

60. Students from poor families will be exempted from even modest parent-teacher association fees and will receive free textbooks and exercise books. Where necessary, school lunches will be provided for these children from the produce generated from school gardens that are supported by UNICEF as part of the nutrition programme. The CAPS project will continue to strengthen teaching and learning in primary school classrooms. Relevant teacher training will be decentralized and a system of school clusters with a central resource centre will be introduced to provide schools and teachers with more information, teaching materials and peer training. More emphasis will be given to parent-teacher collaboration, improved classroom management and optimal teaching and learning methods.

Child rights

61. The rights of the child are a major foundation of the present country programme. While relevant themes of promoting and protecting one or more rights of children are incorporated into all programmes, overall implementation of the Convention on the Rights of the Child will be supported through the child rights project. In areas where specific projects do not yet exist, support will be given to undertake the necessary reviews and surveys to develop a better understanding of the nature and scope of problems. This includes some areas of children in especially difficult circumstances and juvenile justice. Wide dissemination of the provisions of the Convention and of Myanmar's Child Law also will be undertaken.

Children in especially difficult circumstances

62. Some needs of children in especially difficult circumstances will be identified through surveys and will be met through health, nutrition, education and water supply and sanitation projects. The extension of services into border areas will address the critical needs of many unserved children. The primary education projects are intended to draw street children and other disadvantaged groups into school. Surveys and applied research will be undertaken on street, working, disabled and abused children, with the active participation of non-governmental organizations. Based on their findings, preventive, rehabilitative and reintegration activities will be designed and put into operation by non-governmental organizations and selected local authorities.

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Community education also will be undertaken to raise awareness of the situation and needs of these groups of children.

Advocacy, information and communication

63. UNICEF advocacy will promote the rights of the child and the decade goals for children at policy, planning, project formulation and implementation levels, with a more effective use of monitoring, communication and social mobilization initiatives.

64. A cross-cutting effort on family empowerment for child development will be incorporated into health, nutrition, water supply and sanitation and education programmes. Beginning with selected townships, this project will aim to reach 90 per cent of all families with information and skills for assessing children's needs and for taking action using low-cost preventive measures and existing services. Township-level teams of community facilitators drawn from non-governmental organization members, religious groups and service workers will be trained in problem identification and support communications. They will draw on the information base and social indicators being developed to strengthen the monitoring system. The Myanmar and local language editions of Facts for Life will be a major resource.

Support to partners

65. Non-governmental organizations will be critical partners in the implementation of the present country programme. However, until recently, many of Myanmar's national non-governmental organizations have had relatively little contact with the international community and with organizations working in other countries. Through workshops, technical assistance, training, sharing of documentation and study visits, UNICEF, in partnership with relevant international non-governmental organizations, will support capacity-building for non-governmental organizations of Myanmar in such areas as situation analysis, goal definition, plan formulation, communications, proposal and report writing, fund-raising and agency management.

Programme management

66. The UNICEF Representative in Yangon has a team of 21 national and international Professional staff. In view of the community focus of the programme, three national officers will be outposted to provide direct support to project development, monitoring and implementation, particularly in the underserved states. UNICEF staff will continue direct monitoring of project inputs and progress through extensive travel to all states and divisions of the country.

Monitoring and evaluation

67. Because data and systems to monitor the situation of children are inadequate, pilot information bases will be developed initially in selected townships and used for situation and programme monitoring at the local level, as well as to develop a national monitoring system. A statistical profile of Myanmar's children will be updated every two years. Progress towards the goals

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will be accomplished through an established system of monitoring of goal status, project reports and annual and mid-term reviews. The organizational strategy of involving ministries, local-level non-governmental organizations and United Nations agencies will also be assessed during the mid-term review.

68. Monitoring and assessment of programme progress involves a number of mechanisms. Project inputs and expenditure are monitored comprehensively by UNICEF on a monthly basis. Annual and mid-term reviews will examine accomplishments and constraints, and adjustments to projects will be made as appropriate. Each project and the country programme as a whole are dynamic in character, ready for adjustment in strategy and inputs as soon as experience indicates this necessary.

Cooperation with other partners

69. WHO, UNDP and the Food and Agriculture Organization of the United Nations (FAO) have contributed directly to the framing of the country programme, drawing on their long-standing cooperation in Myanmar. All four agencies cooperated in follow-up to the International Conference on Nutrition and the resulting draft plan of action has been used to link agency programmes. UNDP and UNICEF have a formal agreement on convergent programme development in Myanmar. UNDP, UNICEF, WHO and the United Nations Population Fund (UNFPA) cooperate closely in the area of HIV/AIDS prevention. UNICEF, UNDP, WHO and the United Nations Centre for Human Settlements have cooperated on a joint review of the water supply and sanitation sector and their recommendations have been incorporated in the present recommendation.

Table 1. Basic statistics on children and women

Myanmar		(1992 and earlier years)		UNICEF country classification	
Under-five mortality rate		111	(1993)	High U5MR	
Infant mortality rate		81	(1993)	High IMR	
GNP per capita	\$	220	(1987)	Low-income GNP	
Total population		44.6 million	(1993)		
KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1993
Births	(thousands)	1103	1233	1397	1446
Infant deaths (under 1)	(thousands)	142	130	122	117
Under-five deaths	(thousands)	196	180	168	160
Under-five mortality rate (per 1,000 live births)		178	146	120	111
Infant mortality rate (under 1) (per 1,000 live births)		129	105	88	81
		About 1980	Most recent		
Underweight children (under 5)	Moderate & severe	47 *		37 *	
(% weight for age, 1981/1991)	Severe	..		11 *	
Babies with low birth weight (%, 1984/1987)		17		16	
Primary school children reaching grade 5 (%, 1970)		27		..	
NUTRITION INDICATORS		About 1980	Most recent		
Exclusive breast-feeding rate (<4 mos.) (%)		..		..	
Timely complementary feeding rate (6-9 mos.) (%)		..		..	
Continued breast-feeding rate (20-23 mos.) (%)		..		..	
Prevalence of wasting (0-59 mos.) (%, 1981/1991)		33 *		11 *	
Prevalence of stunting (0-59 mos.) (%, 1981/1991)		48 *		40 *	
Daily per capita calorie supply (% of requirements, 1979-1981/1988-1990)		108		114	
Total goitre rate (1990)		..		18	
Household expenditure (% of total income)	All food/cereals	..		.. / ..	
HEALTH INDICATORS		About 1980	Most recent		
ORT use rate (%, 1986/1993)		21		37	
Access to health services	Total	50		60	
(% of population, 1980/1992)	Urban/rural	100 / 31		100 / 47	
Access to safe water	Total	21		39	
(% of population, 1980/1993)	Urban/rural	38 / 15		39 / 39	
Access to adequate sanitation	Total	21		42	
(% of population, 1980/1993)	Urban/rural	38 / 15		46 / 41	
Births attended by trained personnel (%, 1988/1990)		57		68	
Maternal mortality rate (per 100,000 live births, 1981)		460		..	
Immunization		1981	1985	1990	1993
One-year-olds (%) immunized against:	Tuberculosis	15	22	75	80
	DPT	5	8	69	73
	Polio	..	1	69	73
	Measles	..	..	73	71
Pregnant women (%) immunized against:	Tetanus	6	13	54	66

* Aged 0-36 months.

Table 1 (continued)

Myanmar

EDUCATION INDICATORS		About 1980		Most recent		
Primary enrolment ratio (gross/net) (%, 1980/1990)	Total	91	/ ..	105	/ ..	
	Male	93	/ ..	107	/ ..	
	Female	89	/ ..	104	/ ..	
Secondary enrolment ratio (gross/net) (%, 1980/1990)	Total	22	/ ..	23	/ ..	
	Male	..	/ ..	23	/ ..	
	Female	..	/ ..	23	/ ..	
Adult literacy rate, 15 years & older (%, 1983/1990)	Total	79		81		
	Male/female	86	/ 72	89	/ 72	
Radio/television sets (per 1,000 population, 1980/1991)		23	/ 1	82	/ 2	
DEMOGRAPHIC INDICATORS		1970	1980	1990	1993	2000
Total population	(thousands)	27102	33821	41825	44613	51567
Population aged 0-15 years	(thousands)	11749	14146	16790	17696	20058
Population aged 0-4 years	(thousands)	4278	4800	6021	6340	6837
Urban population (% of total)		22.8	24.0	24.8	25.7	28.4
Life expectancy at birth (years)	Total	49	52	56	58	61
	Male	47	50	55	56	60
	Female	50	54	58	60	63
Total fertility rate		5.9	5.1	4.3	4.1	3.6
Crude birth rate (per 1,000 population)		40	37	33	32	29
Crude death rate (per 1,000 population)		17	15	12	11	9
		About 1980		Most recent		
Contraceptive prevalence rate (%, 1988/1991)		13		17		
Population annual growth rate (%, 1965-1980/1980-1993)	Total	2.2		2.1		
	Urban	3.1		2.7		
ECONOMIC INDICATORS		About 1980		Most recent		
GNP per capita annual growth rate (%, 1965-1980)		1.6		..		
Inflation rate (%, 1970-1980/1980-1992)		11		15		
Population in absolute poverty (%, 1978)	Urban/rural	40 / 40		.. / ..		
Household income share (%)	Top 20%/bottom 40%	.. / ..		.. / ..		
Government expenditure (% of total expenditure, 1980/1991)	Health/education	5 / 11		7 / 17		
	Defence	22		22		
Household expenditure (% share of total, 1986/1989)	Health/education	2 / 2		3 / 1		
Official development assistance: (1981/1992)	\$US millions	284		126		
	As % of GNP	5		..		
Debt service (% of goods and services exports, 1982/1992)		26		11		

Table 2. Expenditure under previous cooperation period, 1991-1995 a/

COUNTRY: MYANMAR
 LATEST BOARD APPROVAL: 1991
 GENERAL RESOURCES: \$25 000 000

(In thousands of United States dollars)

Programme sector/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		General resources		TOTAL SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	7 602	1 811	597	9	109	192	2 791	192	11 099	10 000	2 012	10 000	13 111	20 000
Water supply and sanitation	5 604	808	41	6	639	8	1 040	8	7 324	7 500	827	5 000	8 151	12 500
Education and early child development	1 609	2	181	2	242	27	939	27	2 971	5 000	31	1 569	3 002	6 569
Social mobilization and advocacy	173		24		23		345		565	1 250			565	1 250
Planning and social statistics	114		129		114		475		832	1 250			832	1 250
Emergency	110	80							110		80		190	
GRAND TOTAL	15 212	2 701	972	17	1 127	227	5 590	227	22 901^b	25 000	2 950	16 569^c	25 851	41 569

GR = General resources.

FSF = Programmes approved for funded supplementary funding.

SF = Programmes for supplementary funding, funded and unfunded.

a/ Actual expenditures include expenditures recorded as of November 1994.

b/ Including expenditures from global fund and additional allocation of general resources for unfunded programmes for supplementary funding.

c/ Of this amount, \$14 483 761 remains unfunded.

Table 3. Planned expenditure, 1996-2000

(In thousands of United States dollars)

Country: MYANMAR Period covered: 1996 - 2000	Funding status	1996	1997	1998	1999	2000	Total
Health	GR	2 600	2 600	2 600	2 600	2 600	13 000
	NSF	2 170	2 170	2 240	2 230	2 190	11 000
Water supply and sanitation	GR	1 260	1 260	1 260	1 260	1 260	6 300
	NSF	1 500	1 500	1 500	1 500	1 500	7 500
Education	GR	1 280	1 280	1 280	1 280	1 280	6 400
	NSF	700	1 000	1 100	1 300	900	5 000
Children in especially difficult circumstances	GR	300	300	300	300	300	1 500
Social mobilization and advocacy	GR	430	430	430	430	430	2 150
Planning and social statistics	GR	630	630	630	630	630	3 150
TOTAL	GR	6 500	6 500	6 500	6 500	6 500	32 500
	NSF	4 370	4 670	4 840	5 030	4 590	23 500
GRAND TOTAL		10 870	11 170	11 340	11 530	11 090	56 000

GR = General resources.

NSF = New programmes for supplementary funding.



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UNITED NATIONS CHILDREN'S FUND
Executive Board
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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Viet Nam

SUMMARY

The Executive Director recommends that the Executive Board approve:

(a) The country programme of Viet Nam for the period 1996 to 2000 in the amount of \$44,000,000 from general resources, subject to the availability of funds, and \$91,000,000 in supplementary funds, subject to the availability of specific-purpose contributions;

(b) Additional general resources in the amount of \$1,261,000 to fund the approved country programme for the period 1991 to 1995 for which the balance of approved general resources is not sufficient to fund the programme up to the approved programme period.

CONTENTS

	<u>Page</u>
THE SITUATION OF CHILDREN AND WOMEN	2
PROGRAMME COOPERATION, 1991-1995	3
RECOMMENDATION FOR ADDITIONAL GENERAL RESOURCES FOR THE APPROVED COUNTRY PROGRAMME, 1991-1995	7
RECOMMENDED PROGRAMME COOPERATION, 1996-2000	8

List of tables

1. Basic statistics on children and women	15
2. Expenditure under previous cooperation period, 1991-1995	17
3. Planned expenditure, 1996-2000.....	18

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. Viet Nam was the first country in Asia and the second in the world to ratify the Convention on the Rights of the Child. Its first report on implementation was characterized by the Committee on the Rights of the Child as being frank, self-critical and forward-looking. The report and the concluding observations made by the Committee highlight concern about the negative effects of the country's ongoing economic transformation on children and women. The situation of children in rural and mountainous areas and of ethnic minority children in remote areas is particularly serious given their low access to health and education services. The issue of juvenile justice is also of concern. The Government is fully aware of these issues and has initiated some corrective actions, using limited available resources.
2. The continued success of Viet Nam's policy of Doi Moi ("renovation") owes much to past investments in child survival, protection and development and to the country's continued commitment to social equity and economic development. The economy is growing at an annual rate of 8 to 9 per cent, inflation is under control, the currency is stable and there is only a modest budget deficit. However, the effectiveness of the social service infrastructure is being threatened, largely by growing disparities between geographical regions and in incomes. Socio-economic changes resulting from economic reforms have a number of major implications on the situation of children and women, including (a) a decrease in income of about 10 per cent of the population and no improvement for another 20 per cent, with ethnic minority and remote upland populations particularly disadvantaged; (b) family units, especially mothers, have increasing responsibility for meeting children's needs; (c) social services increasingly are being provided, for fees, by sources other than the Government, including the private sector and NGOs, with a corresponding proliferation of information and advertisements on how to meet children's needs; and (d) despite the generally good situation of women, poverty is a serious problem for many. One fifth of all households are headed by single women, and in some remote areas, the proportion reaches almost 50 per cent.
3. The infant mortality rate (IMR), estimated at 46 per 1,000 live births, has fallen from 80 per 1,000 in 1980, a decline of 45 per cent, or 71,000 infant deaths per year. The under-five mortality rate (U5MR), estimated at 81 per 1,000 live births, declined by 31 per cent between 1980 and 1992, representing 64,000 fewer child deaths each year. However, there are major variations among the urban, delta, coastal and mountainous areas, with one province having an estimated U5MR of 148 per 1,000 live births.
4. Acute respiratory infections (ARI) account for 33 per cent of all infant deaths and diarrhoeal diseases for another 25 per cent. Over one half of the country's 10,000 communes do not yet have health workers trained in case management for ARI and diarrheal diseases. Achieving the goals for oral rehydration therapy (ORT) and ARI by 1995 will contribute significantly towards meeting the country's goals for reducing IMR and U5MR by the year 2000. Other major causes of infant and child morbidity and mortality are malaria, neonatal tetanus and measles.
5. Estimates of Viet Nam's maternal mortality rate (MMR) range between 110 and 220 per 100,000 live births. The number of women who deliver their babies at health centres is declining. Two thirds of pregnant women are anaemic and 17 per cent of infants are born with low birth weight. Traditional practices, including continued hard work up to childbirth and reduced food intake during pregnancy, contribute to these conditions. Mothers rarely give colostrum to babies and usually do not breast-feed until two to three days after delivery. Slightly more than one third of mothers breast-feed exclusively during the first month.

6. An estimated 43 per cent of children under five years of age suffer from protein-energy malnutrition (PEM); 13 per cent are severely malnourished. Malnutrition rates may be higher in poorer provinces of the country. Nearly two times as many children aged one to three years as infants suffer from malnutrition. The prevalence of corneal scars attributed to vitamin A deficiency is 0.12 per cent, nearly two and one half times higher than the public health significance level of 0.05. A 1993 nationwide survey showed that 94 per cent of the population suffer from iodine deficiency disorders (IDD), with 50 per cent of all iron deficiency anaemia occurring among pregnant women and pre-school children. A national programme for universal salt iodization is being implemented.

7. Although Viet Nam has relatively abundant water resources because of high rainfall, major problems are caused by saltwater intrusion in coastal areas and flash floods caused by extensive deforestation in upland areas. Surface water sources are increasingly polluted because of the intensive use of pesticides and fertilizers and industrial discharges of untreated waste water into rivers. About 32 per cent of the rural population have access to safe water. If the trend of the past three years continues, 80 per cent of people in rural areas will have access to safe water by the year 2000. Water collection poses a serious burden, in terms of time and energy expended, on rural women and girls.

8. About 15 per cent of rural households have access to sanitary means for disposal of excreta. Such practices as using human excrement as fertilizer must be stopped. A study on intestinal parasite infection found infection rates of 95 per cent in the north, where double-vault compost latrines are used, and 40 per cent in the south, where fish-pond latrines are common.

9. Viet Nam continues to have a high literacy rate (85 per cent), but its sustainability is threatened by a nationwide shortage of over 50,000 teachers, with 20,000 teachers needed in ethnic minority areas, and a total of 2.2 million children aged 6-14 years who have never enrolled in school or dropped out soon after starting grade one. Although members of ethnic minorities comprise about 13 per cent of the total population, their school enrolment rate is only about 4 per cent. Women account for 71 per cent of the 8 million illiterate people in Viet Nam.

10. There are an estimated 3 million children in especially difficult circumstances in Viet Nam, including disadvantaged ethnic minority children, and street children and working children.

11. The number of people infected with the human immunodeficiency virus (HIV) is increasing rapidly because of changing patterns of sexual behaviour, including the rapid growth of commercial sex. By mid-1994, there were 1,490 reported cases of HIV, although adequate diagnostic facilities do not exist.

12. Overall, Viet Nam is making progress in ensuring high rates of child survival. Problems of child development remain more intractable, although clear plans for accelerated progress are now in place. The status of child protection requires further assessment, analysis and action.

PROGRAMME COOPERATION, 1991-1995

13. The national programme of action (NPA) for children for the period 1991-2000 was adopted in December 1991. The completion of provincial programmes of action in each of Viet Nam's 53 provinces provides a focus for convergent and mutually reinforcing interventions for child survival, development and protection. In some provinces, district plans of action have been prepared. Further indication of Viet Nam's commitment can be seen in the appointment of a Minister for Child Care and Protection.

14. In 1993 and 1994, the Government made major increases in budgetary allocations to the social sector and specific allocations for achieving the goals for children for mid-decade and the year 2000. For example, allocations for achieving the nutrition goals increased by 1,500 per cent. Budgets for health and population programmes were increased by 250 per cent, for education by 30 per cent and for rural water supply and sanitation by 550 per cent. The Vice-President has established a National Fund for Children, a non-governmental organization (NGO) committed to raising funds in support of implementing the Convention on the Rights of the Child and the NPA.

15. The 1991-1995 programme of cooperation made some important contributions to implementing the NPA. Achieving and maintaining the mid-decade goals by the end of 1995 will reduce substantially IMR, U5MR and the prevalence of malnutrition. Viet Nam is well on the way towards achieving the goals for the decade for education and water supply and sanitation.

Health

16. There has been major progress in rehabilitating the primary health care (PHC) infrastructure. Following a review of PHC implementation in November 1992, a process was initiated to integrate vertical PHC services in phases in one district in each of the 53 provinces by 1995. In 1993-1994, equipment was provided to 1,279 communal health centres (out of 10,000 communes). Thousands of health workers received in-service training which emphasized the mid-decade goals and other priorities. New approaches to health financing along the lines of the Bamako Initiative were established in 42 of 550 districts on an experimental basis, and this initiative is expanding rapidly.

17. Immunization coverage of infants has exceeded 85 per cent for all six antigens of the expanded programme on immunization (EPI) for four consecutive years. Coverage for pregnant women with tetanus toxoid increased sharply from 14 per cent in 1991 to 71 per cent for 1993. Nationwide mass vaccination campaigns, strengthened social mobilization, increasing local resource mobilization, wide coverage of monthly vaccinations and major support for local vaccine production were the strategies used to achieve the mid-decade goals and sustain universal child immunization (UCI). Technical assistance provided by the World Health Organization (WHO) focused on improving disease surveillance skills and laboratory technology. UNICEF provided cold-chain and injection equipment and in-service training.

18. The programme for the control of diarrhoeal diseases (CDD) reaches 87 per cent of communes and is on course to achieve the mid-decade goal of 80 per cent use of ORT. Currently, 78 per cent of children under five years of age are given ORT, compared to 60 per cent in 1991. In 1994, UNICEF cooperation promoted local production of oral rehydration salts (ORS) for capacity-building and sustainability.

19. UNICEF helped to provide in-service training, basic supplies and equipment for the control of ARI, malaria and trachoma. Coverage of ARI control expanded from 18 per cent of communes in 1990 to 45 per cent by the end of 1993, reaching 40 per cent of children under five years of age. ARI control will expand to 55 per cent of communes in 1994 and 65 per cent in 1995. The major constraint to expansion is a lack of funds.

20. Constraints to further progress include greater use of inappropriate self-diagnosis and treatment by unregulated pharmacists, both of which decrease use of public health services. Low morale among poorly paid health workers is both a cause and effect of those factors. National capacity to effect major behavioural changes in health is very limited, and there is a widespread lack of community knowledge on child health issues.

Nutrition

21. To help develop a strategy to achieve the NPA nutrition goals, UNICEF assisted an assessment and analysis of the magnitude and causes of child malnutrition (PEM, IDD and vitamin A deficiency). A national consensus was reached on the systematic use of the "triple A" strategy (assessment, analysis and action), appropriate mid-decade goals were set and comprehensive plans of action to achieve them were formulated and implemented, with 20 per cent of the country covered by the end of 1994. Implementation involved cooperation with other agencies, including the Food and Agriculture Organization of the United Nations (FAO), the World Food Programme (WFP) and WHO, and NGOs and other multilateral organizations, including the World Bank.

22. Control of PEM focused on strengthening growth monitoring and promotion with mothers of children under five years of age, nutrition education for mothers and other caregivers, and support to 68,300 households from 1991-1993 to increase food security through family food gardening.

23. Control of vitamin A deficiency expanded to 93 per cent coverage through the provision of locally produced vitamin A supplements to almost 10 million children aged six months to five years and to women in the first month of lactation. FAO and UNICEF supported nutrition education to promote such dietary changes as the consumption of foods rich in iron and vitamin A.

24. After a national assessment in 1993 showed IDD to be a nationwide problem, the distribution of iodized salt was expanded to cover not only the mountainous areas, but also lowland and delta areas. Currently, 24 per cent of all salt is iodized with 80 per cent coverage planned for the end of 1995.

25. A government decree banned the sale or free distribution of breast-milk substitutes and promoted the Baby-Friendly Hospital Initiative. UNICEF helped to encourage caregivers to improve infant feeding practices by providing information and education through the Viet Nam Women's Union (VWU), establishing home-based day care and providing credit to increase household incomes.

26. The prospects for achieving the mid-decade and other goals for nutrition are excellent. Given the impact of nutrition on under-five mortality in Viet Nam, sustaining their achievement will make a major contribution to reducing IMR and USMR.

Water supply and sanitation

27. Rural water supply activities have been expanded to all 53 provinces. By August 1994, about 18.3 million people, or 32 per cent of the population, had access to safe water through 110,000 water points. Around 35 per cent of the rural population will have access by the end of 1994 and 42 per cent by 1995. Continuing this progress would meet Viet Nam's mid-decade goal for water supply and put the country on course to achieve the NPA goal of 80 per cent access by the year 2000. In addition to providing assistance for service delivery, UNICEF also supported capacity-building through the training of government staff and concomitant development of provincial water plans. A 1992 evaluation of hand-pumps showed that over 90 per cent were in correct working order because almost every pump has a trained caretaker, usually a woman.

28. During the programme period, more than 100,000 sanitary latrines were installed. A major sanitation education effort undertaken with VWU expanded activities and mobilized more family resources. More than 2,000 of the nation's 13,000 primary schools have been provided with water supply and sanitary facilities. More rapid progress in the water supply and sanitation sector is constrained by a lack of funds.

Education

29. Constraints to achieving universal primary education include a shortage of primary school teachers (because of recruitment and retention problems), poor school facilities and such socio-economic factors as insufficient family income for school supplies and heavy child workloads, especially for girls aged 10 years and older. UNICEF support has concentrated on promoting multigrade teaching as a strategy for increasing access to primary school, particularly for girls and disadvantaged ethnic minority children. The programme expanded from 20 schools in 1991 to more than 1,100 in 1994. An independent assessment endorsed the multigrade teaching strategy, but recommended further improvements in teacher training. UNICEF discontinued support for pre-vocational education and education for disabled children in favour of increased concentration on the main goal of universal primary education.

Women in development

30. Beginning with the widespread diffusion of Facts for Life, the programme expanded in 1993 to include a revolving credit scheme for income-generation activities. Families with malnourished children and/or children who could not attend school because of poverty were the priority target groups for loans, which averaged \$30 per family and covered 18,400 families in 1993 and 1994. The repayment rate exceeds 98 per cent and malnutrition has declined by 80 per cent in Thanh Hoa province because of the entrepreneurial spirit, hard work and discipline of the Vietnamese women using the loans. This strategy of combining small-scale credit for income generation with Facts for Life knowledge has proven to be a cost-effective approach for women's empowerment and the sustained reduction of malnutrition. The programme, now endorsed by the Viet Nam Bank of Agriculture, is becoming a stepping stone for borrowers to graduate into the formal banking system.

Children in especially difficult circumstances

31. In response to issues raised in Viet Nam's report to the Committee on the Rights of the Child, UNICEF helped to establish experimental drop-in centres for street children in major cities, supported the training of front-line workers in social work and child-care practices, and promoted the involvement of NGOs in preventing the spread of HIV and acquired immune deficiency syndrome (AIDS). None the less, the capacity of both the Government and NGOs to deal with children in especially difficult circumstances remains weak.

Advocacy and social mobilization

32. Because there is limited national capacity to promote community and individual behavioural change, UNICEF provided assistance for training activities to the Committee for the Protection and Care of Children (CPC), the Ministry of Health, VWU, radio and television networks and NGOs. The country's already strong capacity for mass mobilization was used effectively to promote EPI, vitamin A distribution and other UNICEF-supported services.

33. There have been considerable increases in supplementary funding, particularly since 1992, because of more effective advocacy and public information on Viet Nam's progress for children with bilateral donors, the private sector and NGOs. Major donors of supplementary funds include the Australian International Development Aid Bureau; the Canadian International Development Agency; the Governments of Luxembourg, the Netherlands and Sweden; the National Committees for UNICEF of Australia, Belgium, France, Japan, the Netherlands, New Zealand, the Republic of Korea, the United Kingdom and the United States; and the NGO and private sectors, including Rotary International, the Sasakawa Foundation and the Italian oil company, ENI-SERMED.

Monitoring and evaluation

34. Following the completion of Viet Nam's NPA in late 1991, UNICEF provided technical and financial support to CPCC and to provincial governments to complete programmes of action in all 53 provinces. UNICEF also assisted the State Planning Committee, the Government Statistics Office and relevant ministries to develop a sound monitoring system for social indicators. This is also an important capacity-building initiative, given the rapid social changes taking place in Viet Nam and resulting widening income disparities and diminishing access to some social services.

Lessons learned

35. Beginning in 1993, UNICEF staff and Government officials increased field monitoring. Through these visits UNICEF learned that (a) UNICEF support was not sufficiently targeted to the needs of the poorest women and children and the most deprived geographical areas; (b) social indicators should be monitored regularly; and (c) given the central importance of the family as the chief provider of child and family care services, there is a need for empowering women, families and communities with information, education and skills. The results of the visits, combined with programme and project assessments, were analysed jointly by the Government and UNICEF and guided the evolution of programme strategies.

RECOMMENDATION FOR ADDITIONAL GENERAL RESOURCES FOR THE APPROVED COUNTRY PROGRAMME, 1991-1995

Annual funding requirements

(In thousands of United States dollars)

<u>Current programme cycle</u>	<u>Approved general resources funding a/</u>	<u>Additional funding proposed</u>	
		<u>1995</u>	<u>Total</u>
1991-1995	40 000	1 261	1 261

a/ The amount shown here includes the actual balance carried over from the previous programme cycle.

36. The programme of cooperation was approved by the Executive Board for the period 1991-1995 with an allocation of \$40,000,000 from general resources (E/ICEF/1991/P/L.16). New challenges arose during that period, mainly because of the impact of economic reforms on poorer families and ethnic minorities, the Government's commitment to make stronger efforts to meet their needs and accelerated progress towards the mid-decade goals. Based on those considerations, especially given high programme implementation and the availability of general resources, a total amount of \$1,261,000 was added to the country programme ceiling for Viet Nam in 1992, 1993 and 1994. To help sustain the pace and successes of programme implementation and maintain the annual planning level at \$8,800,000 for 1995, approval of additional general resources in the amount of \$1,261,000 is being requested.

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RECOMMENDED PROGRAMME COOPERATION, 1996-2000

General resources: \$44,000,000

Supplementary funds: \$91,000,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Advocacy, social mobilization and communication	3 000	1 500	4 500
Planning, research, evaluation and monitoring	1 000	1 500	2 500
Health	13 000	28 500	41 500
Nutrition	4 500	9 000	13 500
Water supply and sanitation	8 000	25 500	33 500
Education	8 000	18 500	26 500
Women in development	2 000	5 000	7 000
Children in especially difficult circumstances	1 000	1 500	2 500
Programme support	<u>3 500</u>	<u>-</u>	<u>3 500</u>
Total	<u>44 000</u>	<u>91 000</u>	<u>135 000</u>

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects show in table 3.

Country programme preparation process

37. Immediately following the October 1993 mid-term review, the Government and UNICEF established a Country Programme Steering Committee comprised of government officials at the ministerial and policy levels and the UNICEF Representative. The Steering Committee was chaired by the Minister for Protection and Care of Children. At the same time, a Country Programme Task Force was established, chaired by the Vice-Minister for Protection and Care of Children and including government officials from relevant ministries and the UNICEF senior programme coordinator. A series of intensive joint planning and programming workshops were held beginning in January 1994, using the situation analysis to identify priority issues, country programme objectives and an overall strategy. A strategy meeting was held in April 1994 to agree on the programme framework and budgetary allocations. As part of the programming process, a subnational consultation was held with selected provincial governments.

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National goals and priorities for children

38. The Government has set policy objectives to Viet Nam to progress rapidly, to match the economic and social advances made by a number of countries in East Asia and to achieve greater success in the global market place. The Government fully appreciates that child survival and development and women's development, both aimed at maximizing human potential, are essential prerequisites for achieving those objectives. The Convention on the Rights of the Child is becoming an important reference for comprehensive legislation for children, and the NPA is a principal means of implementing the Convention in order to achieve these national ambitions.

39. NPA goals to be achieved by the year 2000 include (a) reduction of IMR by one third through a strategy of reduction by 40 per cent in provinces with high IMR and by 20 per cent in provinces with low IMR, saving the lives of 33,000 infants annually; (b) reduction of USMR by 20 per cent, saving the lives of 15,000 children annually; (c) reduction of MMR by 45 per cent, saving the lives of 800 women annually; (d) reduction of PEM from 42 to 30 per cent among children under five years of age, which will result in over 1,200,000 young children becoming well nourished; (e) sustaining the elimination of vitamin A deficiency, iodine deficiency and iron deficiency anaemia; (f) increasing rural water supply coverage from 42 per cent in 1995 to 80 per cent; (g) increasing rural sanitation coverage from 23 per cent in 1995 to 60 per cent; (h) achieving a primary school completion rate of 90 per cent for 15-year-olds, with the remaining 10 per cent completing grade 3 and being literate; (i) improving the knowledge of cost-effective child-rearing practices among all parents and child-care providers through the dissemination of 10 basic Facts for Life messages to 12 million women and adolescent girls through VWU; and (j) improving the well-being of children in especially difficult circumstances by increasing their access to basic services in urban and ethnic minority areas.

Country programme objectives and strategy

40. The overriding goals of the proposed country programme are to support the Government and families in sustaining the significant past gains in child survival during this early period of transition into a market economy, to implement the Convention on the Rights of the Child and to help to selected NPA goals that are most relevant to UNICEF. The proposed country programme will contribute towards the above-mentioned national goals by achieving the following objectives:

(a) Sustaining UCI coverage at 90 per cent, eliminating neonatal tetanus, eradicating polio and reducing the 1990 levels of measles morbidity and mortality by 90 and 95 per cent, respectively;

(b) In order to revitalize PHC and maternal health care in 142 of the poorest districts, expanding services to treat ARI from 55 to 100 per cent of the communes and treating 80 per cent of diarrhoeal cases with ORS and continued feeding;

(c) Reducing young child malnutrition from over 40 per cent to less than 30 per cent in 142 of the poorest districts through enhancing the status, knowledge and skills of care providers and increasing household food security and access to credit;

(d) Achieving and sustaining virtual elimination of vitamin A deficiency, eliminating IDD and substantially reducing anaemia;

(e) Providing access to a safe water supply to an additional 18 million persons, access to sanitation facilities to 1.2 million persons and water and

sanitation facilities to 5,000 primary schools, along with hygiene and health education;

(f) Upgrading the primary school curriculum, improving the quality of teacher training, modernizing teaching techniques and increasing access to education for 1.5 million disadvantaged children, mainly of the H'mong, Khmer and Cham minorities;

(g) Enhancing the status and participation of women through functional literacy and use of Facts for Life, access to credit and gender-disaggregated monitoring of social indicators;

(h) Improving the status of children in especially difficult circumstances by strengthening government capacity for needs assessment and establishing plans and preventive programmes in partnership with NGOs;

(i) Establishing and maintaining a mechanism to monitor social indicators within the Government General Statistics Office.

41. Six interlinked programme strategies have been selected to support the poorest families, particularly to help them manage and cope with the economic transition, and to monitor social change to ensure effectiveness and efficiency of national policies and programmes. The strategies are: (a) social mobilization and policy advocacy for priority attention for children, resource mobilization and development education; (b) empowering all Vietnamese families with the information and education necessary for them to meet the survival, development and protection needs of their children and women in a rapidly changing society; (c) reducing disparities between geographical areas, ethnic groups and within communities and households; (d) promoting the convergence of services, especially for the poorest areas and families so as to maximize synergy; (e) establishing strong direct links between the country programme and the provincial programmes of action for children; and (f) building into the country programme mechanisms to take advantage of and respond flexibly to rapidly changing national circumstances.

Coverage

42. The proposed programme structure is divided into two parts. The first consists of programmes and projects that will be expanded to achieve national coverage: EPI; CDD; control of ARI; interventions to eliminate vitamin A and iodine deficiencies, e.g. universal salt iodization; rural water supply; promotion of correct infant feeding practices; monitoring of social indicators; and communications and social mobilization.

43. The second part will consist of an area-focused programme to be implemented progressively in the poorest 142 districts of the country. Activities include primary and maternal health care, reduction of malnutrition, primary education (especially for girls), women in development, children in especially difficult circumstances and strengthening the capacity of local governments for planning, coordination and management. The 142 selected districts comprise the four poorest from each of the 17 poor provinces, three from each of the 19 medium provinces and the single poorest district from each of the 17 richest provinces. There will be an explicit effort to promote replication in other provinces using central and provincial government counterpart funding, with progressively higher government inputs in the richer provinces. National programmes include substantial activities for service delivery through existing infrastructure, and the programme for the 142 districts includes a greater emphasis on capacity-building and empowerment.

44. General resources will be concentrated on the poorest areas. Every effort will be made to raise the supplementary funds required for full implementation

of the country programme. Supplementary funding will be used for nationwide expansion of basic services in health, nutrition, water supply and sanitation, education, women in development and for innovative work for children in especially difficult circumstances and monitoring and evaluation.

Advocacy and social mobilization

45. UNICEF will continue to mobilize the Government's political commitment and the highly influential mass organizations to support the achievement of the NPA goals, the country programme objectives and implementation of the Convention on the Rights of the Child. Advocacy will continue to reinforce the prominence of these assets in the light of market reforms and growing budgetary pressure on all levels of government and society. The country programme also will identify and use selectively the new private sector and other voluntary associations to support these efforts. Training of the technical and programme staff of mass media and mass organizations will help to transform "campaign"-style communications to a style that will ensure sustained behavioural change. UNICEF will support audience and behavioural research so that all activities will be appropriate and cost-effective. The interpersonal communication skills of commune-based workers, such as health workers, will be improved through training and more supportive supervision.

Planning, research, evaluation and monitoring

46. To meet the urgent need for accurate data on children and women during a period of very rapid change, priorities will include (a) the development and maintenance of a programme for accurate monitoring of social indicators in order to improve national and subnational capacities for accurate, timely and comprehensive monitoring of progress; (b) continuation of biannual programme implementation reviews and frequent and focused field travel as part of programme monitoring and evaluation; (c) phasing of independent evaluations of major programmes and projects over the programme cycle, with results fed into the annual programme review process; and (d) increased integration of research, monitoring and evaluation in order not to overburden procedures and to improve the quality and cost-effectiveness of data collection and analysis.

Health

47. Four principal strategies will be used to strengthen the PHC network at the community level: (a) universal coverage against the six EPI diseases, ARI and diarrhoea, together with associated health education which will employ the effective social mobilization and communications strategies used in support of UCI; (b) reduction of disparities by strengthening health services and their links with other UNICEF-assisted programmes in the 142 districts; (c) integration at all levels of vertically organized PHC services, such as those for CDD and EPI, and improved coordination with health projects supported by such other partners as the United Nations Population Fund (UNFPA), WFP, WHO, the World Bank, the Swedish International Development Authority and NGOs; (d) strengthening of sustainability through the integration of vertical health services to reduce costs and increase efficiency, establishment of a revolving drug fund, increased community participation and local production of ORS and combined diphtheria/pertussis/tetanus and tetanus toxoid vaccines.

48. An estimated 1.9 million infants (90 per cent) will be immunized annually with the six EPI antigens, 2 million pregnant women (90 per cent) will be immunized with at least two doses of tetanus toxoid, 4.8 million children under five years of age (100 per cent) will receive two doses of oral polio vaccine and 432,000 children aged between 9 and 32 months (90 per cent) in 3,500 remote mountainous communes (30 per cent) will receive one dose of measles vaccine as part of two national immunization days each year in 1996, 1997 and 1998. Vitamin A supplementation will be provided to all 10.5 million children under

five years of age and to 2 million lactating mothers twice each year, with the second dose given on national immunization days. There will be a increased emphasis on disease reduction and cooperation with WHO to improve surveillance and safe injection practices.

49. CDD services will be expanded to cover all communes. The provision of imported ORS by UNICEF (currently 4 million packets) will be phased out gradually as support is provided to increase local production. The four regional and 53 provincial diarrhoea treatment units will conduct 100 training courses on case management and interpersonal communications for community health workers (CHWs), as well as 25 training courses on supervisory and monitoring skills for provincial and district health workers. National and regional teams will be trained to respond to and manage epidemics. Prior to the known seasons of diarrhoea outbreaks, assertive educational campaigns will be mounted to promote personal hygiene, the use of ORT and continued feeding, and to ensure the availability of ORS for severe cases of dehydration. UNICEF will support workshops for private practitioners, pharmacists and midwives to secure their support in promoting correct case management and health education and to counter media promotion which prescribes use of ineffective drugs. This effort will involve collaboration with the mass media, NGOs and such professional groups as the medical and paediatric associations. Monitoring of CDD and ARI services will be improved by the re-establishment and reinforcement of seven sentinel provinces which are representative of different socio-geographical areas nationwide.

50. Services for the control of ARI will aim to reduce infant pneumonia by 60 per cent and in children under five years of age by 40 per cent, using 1995 levels as a baseline. Coverage will be expanded gradually to all communes. The two regional and 53 provincial treatment units will conduct 140 training courses for CHWs and on one additional day for members of mass organizations, in addition to 25 courses for district and provincial paediatricians and 20 seminars on standard case management for private practitioners each year. The purpose of training and mobilization of the mass organizations is to have timely referral in 90 per cent of cases and to increase standard/correct case management to 90 per cent of pneumonia episodes at commune and district health centres. A revolving fund will be established to ensure adequate availability of antibiotics and other essential drugs to treat ARI.

51. The experience gained in strengthening PHC during the period 1993-1995 will be expanded to cover the 142 poor districts. Plans of action will be formalized between UNICEF, the Ministry of Health and district authorities. UNICEF cooperation will cover 40 per cent of the districts in the 17 poor provinces, 33 per cent of districts in medium provinces and 10 per cent in each of the more affluent provinces. Local governments will devote their own additional resources to achieve 100 per cent coverage in their jurisdictions. Basic equipment and essential drugs will be supplied to 2,840 communal health centres, supporting intercommunal polyclinics (which serve more than one commune and have a larger variety of functions than the communal health centres) and 142 district health centres. A revolving fund will be established to promote and manage PHC in each commune. The 25 secondary medical schools and regional institutes of hygiene and epidemiology will be strengthened to train communal and district workers. Short-term training interspersed with periods of work, supportive supervision and achievement incentives will be used to expand coverage to remote and mountainous areas. Professional staff at the Ministry of Health, provincial hospitals and other institutions will provide technical support. Implementation will be monitored by strengthening the routine reporting system and through systematic field visits.

52. Maternal health care and safe motherhood services will be strengthened as part of the revitalization of PHC in the 142 districts. Two health workers in each of the 2,840 communes will be trained using revised guidelines for maternal

and child health care and family planning. District and provincial staff will be trained to provide technical and supervisory support. Health education on risk factors and risk behaviour and training on clean deliveries and clean umbilical cord care for all deliveries will take place in the 142 poorest districts and in 210 districts with a high risk of neonatal tetanus. UNICEF will provide basic equipment and assist information, education and communication activities. UNFPA will provide contraceptives to reduce abortions and menstrual regulation by at least 40 per cent.

Nutrition

53. The main focus will be on decreasing PEM among children under five years of age, the virtual elimination of vitamin A and iodine deficiency and substantial reduction of iron deficiency among children and women. The PEM and iron deficiency components will be implemented in the 142 poorest districts through a strategy of convergent delivery of services, i.e., access to preventive and curative health services, increased household food security and credit for income generation, and the promotion of correct infant feeding and caring practices through trained nutrition volunteers, VWU cadres and day-care workers. IDD will be virtually eliminated through universal salt iodization. Vitamin A deficiency will be virtually eliminated through a combination of supplementation for 10 million children between the ages of 6 and 59 months and 2 million lactating mothers, nutrition education for all families and the provision of seeds for foods rich in vitamin A and seedlings for 300,000 poor households in the 142 poorest districts.

54. Information to increase exclusive breast-feeding during the first four months and on correct infant feeding practices will be disseminated nationally. All 600 hospitals with maternity wards in the 142 poorest districts will achieve "baby-friendly" certification. The ban on free and subsidized distribution of infant formula will be enforced.

55. UNICEF will work closely with FAO, WHO, the World Bank and NGOs in reducing PEM and micronutrient deficiencies. Local production of vitamin A fully meets the country's needs; the country probably will be able to produce the required 420,000 metric tons of iodized salt by 1995. UNICEF will support research on food fortification, private sector involvement and cost-recovery for sustainability.

Water supply and sanitation

56. UNICEF will support the installation of 186,780 new water systems for some 18 million people to help provide 60 per cent of the rural population with access to safe water. An estimated 190,000 caretakers will be trained on maintenance and repair of pumps. Priority will be given to ethnic minority and other low-income and underserved areas. Surveys will identify suitable sources of water for developing gravity-fed systems in mountainous areas, and training will be conducted to strengthen the technical skills of staff in these remote areas. Improved maintenance and stronger links with sanitation and hygiene education will be emphasized and supported by establishing communal water and sanitation committees.

57. UNICEF assistance for the sanitation component will cover a mix of interventions: (a) communication and education for behavioural change; (b) supplies for the construction of 243,000 latrines; (c) capital to establish a revolving fund for latrine construction and smokeless chulas (fuel efficient ovens); (d) mobilization of mass organizations to promote the construction of latrines; and (e) installation of water supply and sanitation systems in 5,000 primary schools to promote hygiene. Information and education activities and training of health workers will focus on linkages between lack of sanitation, poor personal hygiene and diarrhoeal diseases. This mix of

interventions should increase access to sanitation from 15 per cent in 1994 to 31 per cent by the year 2000.

Education

58. The main focus of UNICEF cooperation will be on increasing enrolment and reducing drop-out rates of primary-school-age children, particular girls and ethnic minorities, who together comprise the majority of Viet Nam's 2.4 million primary-school-age children who currently are not in school. A strategy of integrated basic services will be pursued in the 142 districts in order to reduce such constraints to school attendance as long distances between schools and a water supply and lack of income to buy school supplies. The programme also will focus on multigrade teaching, teacher training and the development of materials. In addition, non-formal basic education will be provided to 665,000 students enrolled in home-based and alternative basic education classes. UNICEF also will help to increase enrolment of children aged one to three years in home-based and other day-care groups with the dual aims of meeting the developmental needs of these children and of giving mothers time for other productive purposes, particularly income generation. UNICEF will help to increase the enrolment of children 3-5 years old in kindergartens attached to primary schools.

Women in development

59. Cooperation will focus on poor women's triple roles as mothers, producers and organizers. Strategies will include income and job creation, improvement of women's knowledge on maternal and child care and nutrition and of women's literacy and child-care facilities. Special efforts will be made to promote gender awareness and sensitivity among decision makers and opinion leaders, to monitor changes in the situation of women and girls and to facilitate development of appropriate government laws and policies for the advancement of women and girls.

Children in especially difficult circumstances

60. The programme covers three projects. The urban services project will strengthen institutional capacity for coordinating urban policies and service delivery to poor urban children. The children in especially difficult circumstances project will help to monitor implementation of articles of the Convention on the Rights of the Child relating to child labour, abuse, sexual exploitation and trafficking, and juvenile justice. In addition, income-generating activities and increased access to credit, health and education will reach 4,200 poor urban mothers and their children, while sustainable and replicable models are developed. An HIV/AIDS component will follow a behavioural change approach to reduce HIV transmission among young people. The third project, for ethnic minorities, will help to increase access of the poor to extension services through improved local planning processes and support to water supply and sanitation activities, education materials, basic health equipment and capacity-building at provincial, district and communal levels.

Programme management

61. A country programme management planning exercise carried out in May 1994 resulted in recommendations concerning modifications in office structure, reporting relationships and staffing to ensure that the office's human resources are deployed effectively to manage the 1996-2000 programme. Some improvements include progressively reducing the number of internationally recruited officers and increasing the number of national staff, strengthening the Programme Planning and Coordination Unit and the social mobilization and communications capacity, and increased monitoring, particularly in the 142 districts. The Ho Chi Minh City sub-office will play a greater role in detailed planning for district programmes in southern provinces.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Viet Nam		(1992 and earlier years)		UNICEF country classification	
Under-five mortality rate		48	(1993)	Middle USMR	
Infant mortality rate		36	(1993)	Middle IMR	
GNP per capita	\$	170	(1993)	Low-income GNP	
Total population		70.9 million	(1993)		
KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1993
Births	(thousands)	1613	1979	2026	2055
Infant deaths (under 1)	(thousands)	181	150	84	74
Under-five deaths	(thousands)	253	207	111	98
Under-five mortality rate (per 1,000 live births)		157	105	55	48
Infant mortality rate (under 1) (per 1,000 live births)		112	76	42	36
		About 1980	Most recent		
Underweight children (under 5)	Moderate & severe	52		42 *	
(% weight for age, 1986/1989)	Severe	13		14 *	
Babies with low birth weight (%, 1980/1989)		21		17	
Primary school children reaching grade 5 (%, 1980)		47		..	
NUTRITION INDICATORS		About 1980	Most recent		
Exclusive breast-feeding rate (<4 mos.) (%)		..		..	
Timely complementary feeding rate (6-9 mos.) (%)		..		..	
Continued breast-feeding rate (20-23 mos.) (%)		..		..	
Prevalence of wasting (0-59 mos.) (%, 1986/1989)		7		12 *	
Prevalence of stunting (0-59 mos.) (%, 1986/1989)		60		49 *	
Daily per capita calorie supply (% of requirements, 1979-1981/1988-1990)		96		103	
Total goitre rate (1986)		..		20	
Household expenditure (% of total income)	All food/cereals	..		.. / ..	
HEALTH INDICATORS		About 1980	Most recent		
ORT use rate (%, 1986/1993)		46		52	
Access to health services	Total	80		90	
(% of population, 1985/1989)	Urban/rural	100 / 75		100 / 80	
Access to safe water	Total	46		37	
(% of population, 1985/1993)	Urban/rural	70 / 32		57 / 32	
Access to adequate sanitation	Total	..		21	
(% of population, 1980/1993)	Urban/rural	.. / 55		45 / 15	
Births attended by trained personnel (%, 1989)		..		95	
Maternal mortality rate (per 100,000 live births, 1989)		..		120	
Immunization		1981	1985	1990	1993
One-year-olds (%) immunized against:	Tuberculosis	..	50	90	94
	DPT	..	42	87	91
	Polio	..	62	87	91
	Measles	..	19	87	93
Pregnant women (%) immunized against:	Tetanus	..	..	..	71

* Eight rural regions.

TABLE 1 (continued)

Viet Nam

EDUCATION INDICATORS		About 1980		Most recent		
Primary enrolment ratio (gross/net) (%, 1980/1990)	Total	109	/ 95	103	/ ..	
	Male	111	/ ..	..	/ ..	
	Female	106	/ ..	..	/ ..	
Secondary enrolment ratio (gross/net) (%, 1980/1990)	Total	42	/ ..	33	/ ..	
	Male	44	/ ..	..	/ ..	
	Female	40	/ ..	..	/ ..	
Adult literacy rate, 15 years & older (%, 1979/1990)	Total	84		88		
	Male/female	90	/ 78	92	/ 84	
Radio/television sets (per 1,000 population, 1980/1991)		93	/ ..	104	/ 41	
DEMOGRAPHIC INDICATORS		1970	1980	1990	1993	2000
Total population	(thousands)	42729	53711	66688	70902	81516
Population aged 0-15 years	(thousands)	19643	24172	27155	28218	30337
Population aged 0-4 years	(thousands)	6916	8394	9212	9430	10193
Urban population (% of total)		18.3	19.3	19.9	20.0	22.3
Life expectancy at birth (years)	Total	49	57	63	64	67
	Male	47	55	61	62	65
	Female	52	60	65	66	69
Total fertility rate		5.9	5.1	4.0	3.8	3.3
Crude birth rate (per 1,000 population)		38	37	30	29	27
Crude death rate (per 1,000 population)		15	11	9	8	7
		About 1980		Most recent		
Contraceptive prevalence rate (%, 1988)		..		53		
Population annual growth rate (%, 1965-1980/1980-1993)	Total	2.2		2.1		
	Urban	3.3		2.6		
ECONOMIC INDICATORS		About 1980		Most recent		
GNP per capita annual growth rate (%)		..		..		
Inflation rate (%)		..		..		
Population in absolute poverty (%)	Urban/rural	.. / ..		.. / ..		
Household income share (%)	Top 20%/bottom 40%	.. / ..		.. / ..		
Government expenditure (% of total expenditure)	Health/education	.. / ..		.. / ..		
	Defence	..		..		
Household expenditure (% share of total, 1980 or 1985)	Health/education	.. / ..		.. / ..		
		.. / ..		.. / ..		
Official development assistance: (1981/1992)	\$US millions	242		586		
	As % of GNP	2		..		
Debt service (% of goods and services exports)		..		..		

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1991-1995 ^{a/}

COUNTRY: VIET NAM
LATEST BOARD APPROVAL: 1991
GENERAL RESOURCES: \$40 000 000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)	Training grants (actual)	Project staff (actual)	Other cash (actual)	TOTAL			
					General resources		SF	
					Actual	Planned	Actual	Planned
Health	GR 7 532 FSF 7 046	GR 1 072 FSF 148	GR 477 FSF	GR 2 681 FSF 2 062	11 762	14 000	9 256	11 500
Nutrition and household food security	GR 2 057 FSF 1 584	GR 249 FSF 112	GR 276 FSF	GR 877 FSF 805	3 459	4 150	2 501	3 750
Water supply and sanitation	GR 5 524 FSF 3 516	GR 199 FSF 84	GR 1 259 FSF	GR 1 523 FSF 1 372	8 505	8 000	4 972	24 750
Education	GR 2 673 FSF 402	GR 494 FSF 128	GR	GR 1 559 FSF 281	4 726	5 000	811	5 000
Young child development	GR 1 155 FSF 25	GR 315 FSF	GR 473 FSF	GR	1 943	3 875	25	4 000
Women-centred programme	GR 170 FSF 13	GR 74 FSF 47	GR 271 FSF 413	GR	515	825	473	1 000
Children in especially difficult circumstances	GR 20 FSF 32	GR 49 FSF 16	GR 60 FSF 9	GR	129	250	57	56
Social mobilization and advocacy	GR 94 FSF 2	GR 88 FSF	GR 31 FSF	GR 339 FSF 16	552	300	18	570
Planning and social statistics	GR 44 FSF	GR 53 FSF	GR	GR 132 FSF 55	229	750	55	284
Programme support	GR 506 FSF 10	GR 15 FSF 2	GR 1 316 FSF	GR 343 FSF 29	2 180	2 850	41	2 221
Emergency	GR 190 FSF	GR	GR	GR	190			190
GRAND TOTAL	19 965	12 630	2 608	537	34 190 ^{b/}	40 000	18 209	50 056 ^{c/}
								90 056

GR = General resources.

FSF = Programmes approved for funded supplementary funding.

SF = Programmes for supplementary funding: ^{a/} funded and unfunded.

^{a/} Actual expenditures include expenditures recorded as of November 1994.

^{b/} Including expenditures from global fund and additional allocation of general resources for unfunded programme for supplementary funding.

^{c/} Of this amount, \$29 893 437 remains unfunded.

TABLE 3. PLANNED EXPENDITURE, 1996 - 2000

(In thousands of United States dollars)

Country: VIET NAM Period covered: 1996 - 2000	Funding status	1996	1997	1998	1999	2000	Total
Health	GR	2 600	2 600	2 600	2 600	2 600	13 000
	NSF	4 550	4 800	5 900	6 600	6 650	28 500
Nutrition	GR	900	900	900	900	900	4 500
	NSF	1 545	1 605	1 790	2 040	2 020	9 000
Water supply and sanitation	GR	1 600	1 600	1 600	1 600	1 600	8 000
	NSF	4 700	5 000	5 200	5 300	5 300	25 500
Education	GR	1 600	1 600	1 600	1 600	1 600	8 000
	NSF	2 584	3 226	3 930	4 107	4 653	18 500
Women in development	GR	400	400	400	400	400	2 000
	NSF	1 000	1 000	1 000	1 000	1 000	5 000
Children in especially difficult circumstances	GR	200	200	200	200	200	1 000
	NSF	300	300	300	300	300	1 500
Advocacy, social mobilization and communication	GR	600	600	600	600	600	3 000
	NSF	300	300	300	300	300	1 500
Planning, research, evaluation and monitoring	GR	200	200	200	200	200	1 000
	NSF	300	300	300	300	300	1 500
Programme support	GR	700	700	700	700	700	3 500
TOTAL	GR	8 800	8 800	8 800	8 800	8 800	44 000
	NSF	15 279	16 531	18 720	19 947	20 523	91 000
GRAND TOTAL		24 079	25 331	27 520	28 747	29 323	135 000

GR = General resources.

NSF = New programmes for supplementary funding.



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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Bangladesh

SUMMARY

The Executive Director recommends that the Executive Board approve the country programme of Bangladesh for the period 1996 to 2000 in the amount of \$87,500,000 from general resources, subject to the availability of funds, and \$162,500,000 in supplementary funds, subject to the availability of specific-purpose contributions.

CONTENTS

	<u>Page</u>
THE SITUATION OF CHILDREN AND WOMEN	2
PROGRAMME COOPERATION, 1993-1995	4
RECOMMENDED PROGRAMME COOPERATION, 1996-2000	10

List of tables

1. Basic statistics on children and women	19
2. Expenditure under previous cooperation period, 1993-1995	21
3. Planned expenditure, 1996-2000	22

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. Many of the world's persistent and pervasive problems find their most extreme expression in Bangladesh: abject poverty, overpopulation, underemployment and unemployment, rapid unplanned urbanization, fragile governance, centralized management, natural disasters and environmental deterioration. Of added importance for children and women are the problems of gender discrimination, premature mortality, widespread illiteracy, early malnutrition and infectious diseases. These problems do not occur in isolation, but are linked together in a chain of recurring causes and effects. For the 118 million people of Bangladesh, particularly the 75 per cent who are women and children, survival, development, protection and participation are enormous challenges.

2. Survival continues to preoccupy both state and civil society despite the enormous gains which have been made. Even before they are born, children in Bangladesh are caught in a web of deprivation. Except for tetanus toxoid injections, now available to a majority of women, only one fourth of the women of Bangladesh receive any form of prenatal care. Fewer than 10 per cent of rural births and only 37 per cent of urban births are assisted by trained birth attendants. Maternal malnutrition, infections during pregnancy, anaemia and repeated pregnancies all contribute to low-birth-weight babies and frequent maternal deaths. Bangladesh's maternal mortality rate (MMR), currently 450 per 100,000 live births, is one of the highest in the world, which means that women have a 1 in 30 lifetime chance of dying in childbirth. The infant mortality rate (IMR) is 84 per 1,000 live births and the under-five mortality rate (U5MR) is 144 per 1,000 live births (down from 154 in 1988). The average life expectancy is 56.5 years for males and 55.7 years for females, making Bangladesh one of the few countries in the world with an adverse sex ratio in this area.

3. While vaccine-preventable diseases have shown a dramatic decline, diarrhoea and pneumonia continue to cause around 170,000 child deaths each year. Micronutrient malnutrition persists despite the initiation of universal salt iodation, vitamin A supplementation and other initiatives. Frequent natural disasters cause extensive loss of life and undermine sustainable development, although the 1991 cyclone caused remarkably few deaths, partly because of better disaster preparedness.

4. Although in 1993 Bangladesh ranked 146 out of 173 countries on the United Nations Development Programme (UNDP) Human Development Index, the country none the less is a resilient innovator. Coverage of the expanded programme on immunization (EPI) rose from 2 per cent in 1985 to more than 70 per cent in 1994. Deaths from neonatal tetanus have decreased from 150,000 to fewer than 75,000 per year. In the country that pioneered it, 93 per cent of the population are aware of oral rehydration therapy (ORT) and more than 60 per cent actually use it. The contraceptive prevalence rate has increased from 2 per cent almost 20 years ago to 45 per cent. Over 96 per cent of the people now have access to safe drinking water, compared to 38 per cent in 1980, and 88 per cent live within 150 metres of a water source, making this perhaps one of the most successful drinking water programmes in the developing world. But this success is clouded by the fact that sanitation coverage continues to be low, at 34 per cent. Educational innovations pioneered in Bangladesh, such as the community-based, non-formal schools of the Bangladesh Rural Advancement Committee (BRAC) and the Government's Integrated Non-Formal Education Programme (INFEP), are known the world over. Non-governmental organizations (NGOs) are involved extensively in all social sector programmes. Despite these successes, however, one glaring failure remains: 68 per cent of children are malnourished, a statistic that is significantly worse than could be expected for Bangladesh's per capita gross national product (GNP) of \$220. In 1990, Bangladesh ranked lowest among 97 developing countries in relation to malnutrition prevalence as compared to GNP.

5. Development needs in Bangladesh range from the demographic and economic to the social and political. A top challenge continues to be the rising population. Even under the best scenario, the population will double by the year 2025, with far-reaching consequences for survival, urbanization, migration, employment creation and landlessness. Although the family planning programme has been an outstanding success, with a contraceptive prevalence rate of 44 per cent in 1994, there are signs that the contraceptive rate has reached a plateau. Therefore, the emphasis must shift from the mere provision of family planning supplies to a more broad-based programme of fertility reduction through social development which address both direct and indirect fertility determinants, including the reduction of IMR and U5MR.

6. Economically, the Government has begun to reform public management and liberalize trade and investment. Even with significant increases in economic growth and stability, poverty trends have not been very positive; 48 per cent of the rural and 44 per cent of the urban population continue to live below the poverty line, which is based on the consumption of fewer than 2,122 calories per day as defined by the Government. Some 29 per cent of the rural population and 21 per cent of the urban population are very poor, with a daily consumption of fewer than 1,805 calories. While rural poverty has declined somewhat, urban poverty has risen along with the urban growth rate which, at 6 per cent per year over three decades, is among the highest in the world. If current trends continue, it is projected that the number of urban poor will increase to 15 million by the year 2000, up from 7 million in 1985. While Bangladesh has increased the proportion of domestic spending on social priorities from 11 per cent in 1990 to 25 per cent in 1994, only 13.5 per cent of official bilateral assistance goes to these social priorities. Even if Bangladesh were to double its GNP in the next seven years, per capita GNP would only be about \$400. Clearly, social development cannot wait for economic development, and Bangladesh is demonstrating that this need not be the case.

7. Although Bangladesh is primarily an agrarian country, industrial and service sector development in the next century will require a labour force that is literate, skilled, adaptable and creative. According to the 1991 census, 26 per cent of the adult female population and 44 per cent of the adult male population are literate. The 1994 State of the World's Children report states that female literacy is 47 per cent of male literacy, while in the developing world as a whole it is 76 per cent. At 81 per cent, primary school enrolment rates are high, having increased from 22 per cent in 1990, but of the 17 million primary-school-age children, fewer than 8 million complete the full five-year primary education cycle. Attendance is 64 per cent, with more girls attending school than boys. Teaching is largely by rote, teachers and teaching materials are lacking in quantity and quality, and classrooms are too few and in disrepair. There are 81 primary-school-age children per teacher. Non-formal education outside the government structure has been successful in rural areas, but less so in urban areas, where about 2 million children between 6 and 10 years of age have no access to education. However, gender disparity in primary school enrolment has virtually disappeared, improving from a 34/66 ratio in 1980 to 49.5/50.5 in 1994.

8. Protection, especially of women and children, continues to pose a major challenge. The Bangladesh Constitution guarantees equal rights to men and women, but the realization of these rights falters in the face of customary practice. Despite the Dowry Prohibition Act (1980) and a Cruelty to Women Act (1983), there has been no decrease in dowry-related deaths or violence against women. Although the mean age at marriage is rising, almost one half of all Bangladesh girls are married before the age of 18 years, leading to earlier and more frequent pregnancies. Women consume 18 per cent fewer calories than men and the majority of women are overworked, underfed, illiterate and in poor health. Female children fare less well than male children with regard to health

care, hospital admission and food distribution within the household. Yet nationally, 10 per cent of households are now headed by women. Up to one third of babies are born with low birth weight, a telling indicator of women's health and, in Bangladesh, a sensitive predictor of children's chances for survival.

9. Participation, from household to House of Parliament, is being realized in different ways in Bangladesh, a country which held its first parliamentary election in 1991. None the less, the gulf between the élite and the rural poor does not seem to be narrowing. Women's limited involvement in politics and decision-making at all levels reduces their participation in and impact on development processes. For children, the notion of participation has been limited primarily to their access to education.

10. The Government increasingly is recognizing and encouraging participation by the private sector and NGOs in economic and social development efforts, and is committed to stimulating such private sector initiatives as the production and marketing of water pumps, sanitary latrines, oral rehydration salts (ORS), salt iodation plants and iodated salt. The Government has begun to recognize the vital importance of decentralizing decision-making and of paying more attention to local needs.

PROGRAMME COOPERATION, 1993-1995

11. The period 1993-1995 was an interim programme cycle so that UNICEF could synchronize its programming cycle with that of the Government, UNDP and the United Nations Population Fund (UNFPA). The objectives of the programme were guided by policy objectives of the Government's five-year plan and the UNICEF medium-term plan concerning poverty alleviation, universal primary education, acceleration of the reduction of infant, child and maternal mortality and the slowing of population growth through improvements in the well-being of children and their mothers.

12. Of the Government's 12 mid-decade goals for children, those for water supply (97 per cent) and sanitation (35 per cent) already have been achieved, and nine more almost certainly will be achieved before the end of 1995: universal child immunization; elimination of neonatal tetanus; reduction of morbidity and mortality due to measles; elimination of polio; universal salt iodation; certification of 100 hospitals as "baby-friendly"; an 80 per cent ORT use rate; 80 per cent vitamin A coverage; and 80 per cent primary school enrolment. Achievement of the malnutrition reduction goal is still in doubt, although new efforts have been launched. While no targets have been set for the regulation of and progress towards the elimination of child labour, this too is an area where encouraging progress has been made.

Health and nutrition

13. This programme, which addressed the major causes of child and maternal mortality, morbidity and malnutrition, received supplementary funds from the Canadian International Development Agency (CIDA), the Overseas Development Administration (ODA) of the United Kingdom, the Swedish International Development Authority (SIDA), the Netherlands Directorate-General for International Cooperation, the Australian International Development Aid Bureau (AIDAB) and the National Committees for UNICEF of Canada, Japan, New Zealand, Switzerland and the United States. Given the country's high immunization coverage levels, the programme emphasized sustaining and expanding coverage to those living in hard-to-reach areas. Using 108,000 existing outreach sites which make 16 million annual contacts with children and mothers, the health delivery package known as EPI-Plus provided three services each to 7 million children up to two years of age (vitamin A supplements, breast-feeding promotion and diarrhoea management) and three services each for 4 million pregnant women

(family planning information, iron-folic supplementation and prenatal care). Widespread use of four EPI-Plus measures alone (measles and tetanus vaccinations and the provision of vitamin A and ORS prevented an estimated 100,000 infant deaths annually. UNICEF provided over 52 million doses of vaccines and related cold-chain equipment each year. Programme communication efforts helped to increase the ORT usage rate to 60 per cent in 1994. At the subdistrict level, an additional 206 ORT "corners" were established in government health facilities. By mid-1994, 1,160 doctors and more than 18,000 basic health workers (60 per cent) were trained in diarrhoea case management. In addition, district coordinators for the control of diarrhoeal diseases were appointed in all 64 districts of the country, and 25,000 Boy Scouts and Girl Guides were mobilized to spread the message about ORT. At the same time, 3,000 health workers (10 per cent) were trained in case management for acute respiratory infections (ARI) and essential drugs were provided.

14. All 265 salt manufacturing units in the country have been provided with salt iodation equipment. A multi-media communication package is now ready to promote the use of iodated salt, which almost all 20 million households in the country should be using by the end of 1995. This programme received supplementary funds from CIDA and ODA. With the World Bank, UNICEF designed the community-based Bangladesh Integrated Nutrition Project to cover 400,000 children and 500,000 pregnant and lactating mothers. Testing of growth monitoring and nutrition education systems, as well as targeted supplementation, were initiated to prevent malnutrition in very young children. The training of trainers and assessors has been completed, and by the end of 1994, 17 out of 100 medical facilities had been certified as "baby-friendly", with many more facilities awaiting certification. The Campaign for the Protection and Promotion of Breast-feeding aims to increase the low prevalence (25 per cent) of exclusive breast-feeding.

Water supply and sanitation

15. With supplementary funding from the Danish International Development Agency, the Swiss Development Corporation, the United Nations Capital Development Corporation, AIDAB, ODA and the National Committees of Canada and Japan, 19,000 pumps and 200,000 latrines were provided during the period 1993-1994. Communities were more involved in installing, managing and maintaining tube-wells. Subsidies for installation are being reduced and users now pay for spare parts. A major new challenge is to rehabilitate tube-wells affected by the declining water-table. Increased access to sanitary latrines, which now cover 34 per cent of the population, is due largely to the use of home-made "do-it-yourself" pit latrines. Sanitation promotion efforts involved a range of affordable latrine technologies which reached more than 17 million people. In two years, about 120,000 "change agents" were trained to motivate communities to improve hygiene practices, and 45,000 tube-well caretakers were trained, more than one third of whom were women.

Education

16. The education sector accounts for the single largest share of the Annual Development Plan, reflecting the Government's serious commitment to achieve the Education for All (EFA) goals. New ways of keeping children in school included a government-funded "food for education" programme in over 12,000 schools. A new learning achievement test (Assessment of Basic Competencies or "ABC"), developed with UNICEF support, has shown a significant improvement in teaching and learning, although with achievement levels of 39 per cent, quality still remains low.

17. UNICEF assistance helped to build institutional capacity at all levels, i.e., to improve the quality of supervision and teaching, particularly by introducing participatory approaches; to develop more relevant and effective

curricula, textbooks, teaching aids and teaching methods; and to support the development and production of textbooks and teachers' guides. Intersectoral linkages, especially with water supply and sanitation programmes, have enriched the curriculum and contributed to increasing the enrolment of girls. Advocacy and social mobilization have been effective in raising public awareness of educational goals and opportunities. To reach 7 million drop-outs and 4 million children and young adolescents who had never enrolled in school, assistance has been extended through INFEP to 30,000 non-formal primary education centres (NFPE) run by some 150 NGOs including BRAC and Gano Shikha Sangatha (GSS). Early childhood education efforts include school preparedness programmes and basic education for children 6-10 and 11-14 years old, tailored to their specific needs and situations. The NGO programme was supported with supplementary funds from CIDA, SIDA, the Norwegian Agency for International Development (NORAD) and the National Committees of Germany, Italy, Japan, the Netherlands and the United Kingdom.

Urban basic services

18. The slum improvement project covered 36,000 families in 200 project sites spread over 25 municipal towns and metropolitan areas. The project supported the development of physical infrastructure, provided credit to more than 8,000 hard-core poor women and offered health and nutrition education. Over 80 health workers and community organizers were trained to provide basic health, sanitation, water and credit-related education and services. In 1994, a few schools for slum children were established in order to gain experience. While impressive progress has been made, after eight years of operation the project has reached fewer than 4 per cent of very poor families and fewer than 2 per cent of urban poor households.

Children in especially difficult circumstances

19. The programme maintained its focus on providing services to street children, while moving simultaneously into new areas of intervention. UNICEF supported the Ministry of Social Services and community-based NGOs in their attempts to meet the needs of approximately 10,000 street children in 15 locations within four major urban centres. Ten drop-in centres were established to test models of cooperation between communities, the Government and NGOs. To develop a database on child labour, a rapid assessment was conducted in partnership with the International Labour Organisation. UNICEF continued to play a facilitating role between the Bangladesh Shishu Adhikar Forum (a coalition of children's rights NGOs) and the Government, helping the Government to prepare a draft country report for the Committee on the Rights of the Child.

Chittagong Hill Tracts

20. As part of a strategy to reduce disparities, the programme for the Chittagong Hill Tracts was expanded from 50 to 75 moujas (multi-village areas). A house-to-house survey identified 16,000 poor tribal families. Of the 50 planned mouja community centres, 25 were under construction in 1994. Each community centre is used for group meetings, non-formal education and nutrition education sessions and also functions as an office and warehouse. Over 60 people received training in leadership and as health workers, birth attendants, and pre-school teachers. Group members received skills training in various relevant areas. UNICEF is the only United Nations agency working in this hilly region, where 50 per cent of the population consists of 14 tribal groups, health infrastructures are not well developed and access to basic services is limited. After eight years of operation, the project covers only 16 per cent of tribal families and 8 per cent of the total households in the area.

Information, advocacy, and social mobilization

21. Efforts are being made to strengthen the capacity of the social communication sector. UNICEF initiated work with several communication and social research agencies in developing more professional communication packages for information and motivation purposes. The "Meena" animation series on girl children, originally conceived in Bangladesh, has become a new symbol for the rights of girls and women in South Asia, with NORAD providing funds for some episodes. Advocacy activities included outreach to the media, the Government, NGOs, service clubs and opinion leaders. Several training sessions for journalists focused on better coverage of child-related topics. Social mobilization efforts have created effective cooperation with a wide range of organizations, including religious and women's groups and service clubs. Participatory planning methodologies involving all government agencies and NGOs have played an important role in developing new partnerships and approaches.

Women in development

22. The programme provided support to the Government's plans to reach girls and initiate gender planning and awareness training as part of regional efforts. It also supported training programmes for 60,000 leaders of landless women's groups in banking, credit management, group dynamics, community participation and life skills. UNICEF continued to work closely with the Grameen Bank and other agencies to improve the economic productivity, independence and status of women and supported over 100 small, local women's NGOs working in related fields. This was made possible with supplementary funding from NORAD and the National Committees of Belgium and New Zealand.

Monitoring and planning

23. The Bangladesh Bureau of Statistics and UNICEF developed, tested and implemented a rapid assessment methodology for monitoring annual progress towards the mid-decade goals. Drawing on the experience of EPI cluster survey methodology, the Multiple Indicator Survey (MIS) collects district-level data on over 22 indicators at a cost of less than \$800 per district. Over 400 investigators and social scientists from the Government, the private sector, NGOs and academic institutions were trained in this methodology. The survey process was computerized using the Survey Analysis System, a locally developed software package. The results of the annual survey were disseminated through a Bureau of Statistics publication, Progotir Pathey ("On the Road to Progress"), which has become a valuable source of subnational data.

24. The data from MIS are used to develop district situation analyses, disseminated in "Kamona", a publication which serves as an important advocacy tool and which is used frequently identify district disparities and to prepare district plans of action. Based on a set of indicators, each district is classified according to its achievement towards reaching the goals. To use the data for planning for children, the country office has developed the District Integrated Database (DISIDE). This computer package uses MIS data together with such other data sources as the national census, the Demographic and Health Survey and the Contraceptive Prevalence Survey to help develop district plans of action for achieving the decade goals. DISIDE helps the Government to refine the National Programme of Action (NPA) for Children, based on the progress of subnational programmes of action for children. DISIDE also supports the monitoring of goals and presentation of data for advocacy purposes. The Bureau of Statistics is working with UNICEF to establish the use of DISIDE at subnational levels.

25. Each year, UNICEF staff in Bangladesh make over 5,000 field trips to various parts of the country for purposes of advocacy, monitoring of programme progress and facilitating programme implementation. To make optimal use of

those field visits, checklists have been designed to alert staff members to the types of information to look for when visiting a health complex, market, pharmaceutical shop, salt iodation plant, school and other sites. The information can be computerized and stored for analysis and monitoring of trends by using the field visit-based information database, referred to as "FIND". This method provides valuable data which can be used for making programme adjustments or for improving supervisory support at local levels.

26. The results and recommendations from the more than 50 studies and evaluations commissioned during 1993 and 1994 have contributed significantly to the lessons learned and thus have influenced the strategy formulation and programme design of the proposed country programme of cooperation.

Lessons learned

27. The outstanding success of EPI in Bangladesh offers important lessons for future programmes. These include the value of sharp targeting on a small, manageable cohort; of involving key organizations in planning and delivery; and of encouraging people to believe that seemingly extraordinarily difficult goals can be reached on time. The availability of district-level data proved vital to the overall success and to a sharper focus on disparity reduction in districts and in terms of coverage. Data were also invaluable in efforts to advocate change and influence policy and practices at all levels. It also has become clear that improving capacity for service delivery by itself is not sufficient. Communication efforts must mobilize communities and address behavioural patterns and expectations so as to stimulate use of services and sustainability of community demand for basic services.

28. Based on the 16 million annual immunization contacts, the transition from EPI to EPI-Plus, which now includes five other activities in addition to immunization, has shown the efficacy of uniting various interventions. Extended to schools, which now offer the unique opportunity to reach large numbers of children because of increased enrolment rates, the combined delivery through a common service point of such other services as water, sanitation and health will increase coverage in a more cost-effective manner.

29. The value of involving communities at all stages of programming cannot be overemphasized. Two thirds of all tube-wells, for example, are paid for through community financing. All successful large-scale programmes in Bangladesh have depended on the empowerment of communities to articulate their needs and to plan for access to services. When information reaches the grass-roots level, communities are able to have a strong influence on project performance. Another lesson is that UNICEF does not always need to provide subsidies, and that even the poor often demonstrate the willingness and ability to pay for essential supplies and services.

30. A training methodology which uses experience or "learning by doing" has been more effective than traditional training based on more abstract approaches in changing the practices and attitudes of government and UNICEF personnel, NGOs and communities. Such training, which includes communication workshops, participatory planning and new technologies, also has opened wider possibilities for the effective dissemination of information and will be developed further.

31. As Bangladesh progresses towards national achievement of most of the mid-decade goals by 1995, disparities at the subnational level have become more evident. For example, although there is almost nationwide coverage of drinking water supply, its availability in the Chittagong Hill Tracts is only 39 per cent. Failure to reduce such disparities means that large numbers of children do not have access to services and information even when the country as a whole appears to be making dramatic progress.

32. Since the Government's ratification of the Convention on the Rights of the Child, UNICEF has promoted child rights by assisting the Government in disseminating child rights messages and devising innovative strategies for implementation and monitoring of the Convention. This area offers enormous possibilities for linking programmes for children with the Convention and for translating the articles of the Convention into reality.

33. While the involvement of mothers is vital to the welfare of children, UNICEF also has learned that insufficient involvement of fathers and other male family members has been an important omission in programmes that have failed or achieved only partial success. In the future, men must be as convinced as women of the importance of social programmes in order to ensure that the programmes' intended benefits, for example, safe motherhood and female education, are achieved.

34. Failure to reduce MMR can be attributed to the faulty design of programmes for the training of birth attendants and to the risk-screening approach without adequate provision for prompt and timely referral to secondary health care facilities. As trained birth attendants are able to treat only a small number of pregnancy complications, if there are to be further declines in IMR and MMR, UNICEF must work more closely with secondary and tertiary referral service levels. This applies equally to the reduction of infant and under-five mortality from such causes as pneumonia, diarrhoea, malaria and even some cases of malnutrition.

35. The South Asian Association for Regional Cooperation (SAARC) Resolution on Children and the Memorandum of Understanding between UNICEF and SAARC have opened new possibilities for dealing with complex issues that transcend borders, such as trafficking in children and women. Regional reviews can be based on reliable socio-economic data and can serve as forums for raising issues that can best be resolved at the regional level, and give UNICEF a new opportunity for advocacy and inter-country networking.

36. Despite its limited resources, UNICEF has a significant role to play in the formation of social development policy and programmes for children. UNICEF is able to develop initiatives and advocate policies which then can be replicated by the Government on a broader scale with assistance from other, often larger, donor agencies. UNICEF, through its advocacy and social mobilization work, also has been successful in acting as a broker between the Government, NGOs, service organizations, employers and other interested parties, bringing them together and creating alliances on such issues as child labour.

RECOMMENDED PROGRAMME COOPERATION, 1996-2000

General resources : \$ 87,500,000
Supplementary funding: \$162,500,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Education	26 500	77 500	104 000
Health and nutrition	17 000	55 000	72 000
Water supply and sanitation	5 500	30 000	35 500
Monitoring, evaluation and research	2 500	-	2 500
Advocacy and planning support	5 000	-	5 000
Grameen Bank	2 500	-	2 500
Urban basic services	8 000	-	8 000
Chittagong Hill Tracts	7 500	-	7 500
Disaster preparedness	5 000	-	5 000
Programme communications	<u>8 000</u>	<u>-</u>	<u>8 000</u>
Total	<u>87 500</u>	<u>162 500</u>	<u>250 000</u>

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also supplementary funded projects shown in table 3.

Country programme preparation process

37. As Bangladesh steps into the twenty-first century, its children of today could be the first generation to see most of their basic needs met. Despite the enormous political, social and economic odds facing Bangladesh, the country has vastly increased its capacity to meet those needs. The prospects are encouraging for achieving all the goals for the year 2000. Reaching them will depend largely on three conditions: (a) increasing domestic and international financial resources for basic social services; (b) continuing to help Bangladesh society with new, sustainable approaches to social development; and (c) more effective implementation of local capacity-building at district and village levels and accountability to communities.

38. Employing innovative participatory methodologies, such key groups as politicians, journalists, academics, donors, bureaucrats and NGO officials were brought together to envision a future that would build on but not be limited by the achievements of the past. Together with members of the Joint Consultative Group on Policy (JCGP) in Bangladesh, UNICEF has participated in the formulation

of a common mission statement. The more general JCGP objectives for Bangladesh include: (a) promoting human security for the vulnerable in areas of employment, food security, health, family planning and basic education; (b) protecting the country's natural resources; and (c) promoting sound governance and strengthening democratic institutions. More specific JCGP objectives include: (a) ensuring access to and effective use of appropriate health services, primary education and safe water and sanitation; (b) achieving equity between men and women for all human development indicators; (c) enabling the poor, particularly women and the landless, to gain access to sustainable employment and to eliminate malnutrition especially among children; (d) reducing vulnerability to natural calamities; and (e) empowering people to participate as active and responsible members of civil society. Those goals and objectives have helped UNICEF and UNFPA to set specific achievement targets within a designated time frame.

39. The Joint Government/UNICEF Advisory Group (JGUAG) has prepared, monitored and periodically adjusted the Bangladesh country programme. JGUAG assumed the primary coordinating role in the planning process, beginning with the convening of strategy meetings which brought together representatives of government ministries, NGOs, donors and other parties. These were followed, over a six-month period, by sectoral meetings to design specific programmes. After a penultimate meeting to review the draft documents, a final preview meeting cleared the draft project plans, which were then finalized by the Government.

Goals and objectives

40. The Government's ratification of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women provides Bangladesh with an enduring framework of policy goals for the survival, protection, development and participation of children and women. The long-term goal of providing all children and women in Bangladesh with their rights under these Conventions will guide programme implementation. The goals of the NPA are an important end-of-decade milestone for the progressive fulfillment of those rights.

41. The NPA goals for the year 2000, which serve as a reference for UNICEF cooperation, are (a) to reduce IMR from 84 to 50 per 1,000 live births; (b) to reduce USMR from 144 (1993) to 70 per 1,000 live births; (c) to reduce MMR from 450 (1993) to 300 per 100,000 live births; (d) to sustain the virtual elimination of iodine deficiency disorders (IDD) and vitamin A deficiency; (e) to reduce severe and moderate malnutrition in children under five years of age from 68 (1993) to 38 per cent; (f) to sustain universal access to safe drinking water; (g) to increase sanitation coverage from 34 (1994) to 80 per cent; (h) to increase the primary school enrolment rate from 81 (1994) to 95 per cent and the completion rate from 44 to 70 per cent through formal and non-formal primary education of equivalent standards, while sustaining the virtual gender equity; (i) to increase the adult (15 years and older) literacy rate from 35 (1991) to 62 per cent, with female literacy rising from 26 (1991) to 62 per cent; and (j) to improve protection of children in especially difficult circumstances.

42. To help achieve the NPA goals, UNICEF will support the following country programme objectives:

(a) Expanding basic service coverage and promoting behavioural change in a phased manner to reach all 64 districts by 1999;

(b) Enhancing the capabilities of 30,000 health workers, 108,000 health outreach sites, 300,000 teachers and 60,000 schools, in addition to the establishment of 8,500 urban schools and 5,000 community centres in the

Chittagong Hill Tracts. From 1999 onwards, the number of direct beneficiaries per year of these interventions will include 12 million children under five years of age, 14 million children 6-10 years old, 170,000 tribal women, 2 million hard-core poor urban women, 500,000 high-risk pregnant women and 1.5 million urban children in especially difficult circumstances;

(c) Implementing innovative, small-scale projects to deal with emerging and important problems, mainly related to protection and participation rights. These will include efforts to address the issue of the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), to prevent child prostitution and trafficking, domestic violence and child abuse, as well as the articulation of children's concerns in family and community decision-making;

(d) Identifying further ways to make compliance with the Convention on the Rights of the Child more operational and sustainable.

Strategies

43. There are eight major cross-cutting strategies that will guide all programmes towards achieving the country programme objectives:

(a) Implementation of the Convention on the Rights of the Child is both an objective and a strategy to achieve the objectives of the country programme. Related advocacy will continue to grow in importance to create a national ethic for desirable action. A rights-based approach depends on the ability of country programme partners to disseminate messages on child rights and to reform existing laws;

(b) The accelerated district approach (ADA) is a strategy of decentralized programming that addresses disparities in services and well-being with reference to gender, ethnicity, geography and socio-economic status. ADA will help to universalize coverage, in a phased manner, of a package of selected health, nutrition, sanitation, primary education and family planning services by the year 2000. The impact of this process of universal district coverage will be assessed by using the DISIDE database at district and division levels where the population bases are large enough, for example, to evaluate the impact of basic services on child survival. Based on the experience in five districts during 1995, ADA should cover progressively all 64 districts in six divisions by the year 2000. While some districts progress more rapidly than others, all should achieve the NPA goals by the year 2000. ADA is also a means for adapting national programmes to reduce disparities and promote the rights of the underserved districts. ADA capitalizes on: (i) the current district-level planning approach taken by the Planning Commission; and (ii) the Government administrative reforms proposed for 1995, which include decentralization and devolution of authority. Supplementary funds are needed to increase the phased coverage of districts under ADA with strategic inputs of supplies, cash and technical assistance for health and nutrition, education and water supply and sanitation. The proportion of supplementary funds received from donors for those programmes will help to determine the number of districts reached and the extent of coverage;

(c) The convergent delivery of services through a single delivery point will increase cost-effectiveness, efficiency and impact. The Bangladesh school system offers a sustainable opportunity to reach over 85 per cent of primary-school-age children and their families with services, information and knowledge. Expanding the capacity of primary schools to promote child-family communications creates an opportunity to accelerate behavioural and attitudinal changes among children and their families, which is necessary for sustainable improvements in health, hygiene and nutrition;

(d) Advocacy for children will be central to the success of the country programme. All programme activities will require mobilizing support at all levels of society, from the élites to villages. Communication initiatives will disseminate the general messages of children's rights and needs and at the same time make people more aware of the specific services being provided. This strategy is a key element to community empowerment and to the creation of demand for services;

(e) The programme will collaborate more systematically with other development partners. UNICEF will refine its already close cooperation with bilateral and multilateral donors and United Nations agencies. At both national and subnational levels, the country programme will support efforts of other partners in the implementation of the NPA goals and of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women. Especially important is more effective collaboration between government bodies and NGOs, both at national and subnational levels. NGOs are a source of innovations, albeit on a limited scale, which have the potential for expansion when collaboration with the Government is extensive, as in the cases of BRAC on basic education and the Grameen Bank on women's development;

(f) The increased ability and willingness of the people to demand and pay for basic social services and supplies is the basis of another strategy. Changes in individual and collective consumer behaviour, brought about by social marketing, mobilization, education and information, make it increasingly possible to broaden private sector participation to meet some basic needs, thus reducing the Government's burden to provide basic social services. In this context, consumers will help to increase their demands for and contributions to basic services and cost-sharing. Participation by beneficiaries would expand as a distinctive Bangladeshi expression of community empowerment;

(g) Strengthening and sustainability of capacities is vital, as programmes cannot be sustained indefinitely unless the capacities of both national and local governments and communities are increased. Building capacity involves the creation of government institutional systems that can thrive even with the turnover of individual civil servants, as well as the creation of such new capacities in the private and NGO sectors as research and development, product development, import substitution and socially innovative technologies. The programme of cooperation will promote a sense of social responsibility in the corporate sector which will be translated into concrete contributions to the achievement of the national goals for children;

(h) An eighth strategy will bring together the ingredients of rights, advocacy and capacity-building to empower societal groups, giving people the knowledge, skills and organizational capacity to follow through on concrete, practical felt needs. These could cover a range of problems such as community management of local primary education, positioning health agencies for and monitoring of such services as EPI and providing themselves with tube-wells and sanitary latrines. UNICEF assistance for the delivery of services or equipment will be matched simultaneously with systematic efforts to increase local capacities through innovative training and improved flows of information aimed at enhancing family and community opportunities, control and choice.

Communication

44. Communication will reinforce all programmes. Using communication methods to change the attitudes and behaviour of all people is the sine qua non for programme effectiveness. Innovative mass media and multi-media techniques will be used, especially through cooperation with local advertising agencies.

45. Facts for Life materials and children's media activities will be central to helping children learn about their own health and development needs. The successful "Meena" campaign will continue as an effective vehicle for reaching children with vital messages on the rights of girls and women. Systematic studies of attitudes and practices and audience reaction will help to refine existing communication techniques and develop innovative new ones.

46. The Progotir Pathay and the State of Bangladesh Children reports will document local initiatives, experiences and lessons. Journalists will continue to be trained in child-related topics, and efforts will be made to fill information gaps at all levels about the situation of and possibilities for children and women.

Education

47. Support to education will represent a major priority area in the new programme. Social mobilization, demand creation and the principles of the Convention on the Rights of the Child will be the central themes. Efforts will be made to retain about 17 million students in school and to achieve the EFA goals for the year 2000. Key aspects of the education programme will include: implementing ADA to achieve greater impact; the convergence of services and resources at the school level; disparity reduction; the empowerment of students, teachers, parents and elected local bodies; and improving school quality. ADA will facilitate increasing the primary school enrolment rate from 81 to 95 per cent and the completion rate from 44 to 70 per cent by increasing the role of parents and communities in the planning, management and monitoring of school performance and learning achievement. This will be done by building capacity within the school management committee, which is the only legislated community-based group, in addition to parent-teacher associations, compulsory primary education committees and women's and youth organizations. Enrolment drives, parent-teacher surveillance of enrolment and attendance, tracking of the 6-year-old cohort and data-based monitoring will be supported as a means of bolstering government initiatives to decentralize the primary education system and to stimulate local-level participation.

48. Schools now offer children, their families and communities unique opportunity for learning. Schools and NFPE sites function as fixed centres for learning. Schoolteachers and others affiliated with schools (e.g., school management committee members) could serve as "change agents" and take education to the villages, thus accelerating behavioural and attitudinal changes in health and related areas and monitoring progress towards the country's goals. Furthermore, children, through child-to-child and child-to-parent activities, could carry health, nutrition and other relevant messages to the household level. Similarly, they could report back to the school on relevant health-related information about their families and neighbours. The primary education system, both formal and non-formal, could reach almost every household in the country on a regular basis.

49. UNICEF will continue to cooperate with the Division of Primary and Mass Education to promote the Government's unified approach to primary education, thus reducing the dichotomy between formal and non-formal education. As the Government alone cannot meet all the basic education needs of its children, collaboration with NGOs, the private sector, religious groups and others is vital. INFEP will be a key partner in the programme, as will a network of over 150 NGOs, including BRAC, GSS and Proshika. The programme will aim to make non-formal education an integral part of primary education planning at all levels.

50. Because a different kind of teaching and learning is needed, emphasis will be shifted away from rote memorization to address the multiple ways in which children learn. In addition to sound mastery of the "3Rs" (reading,

writing and arithmetic), children need new "life skills" to face the challenges of the next century. Improvements in curriculum development and teacher training and supervision will promote methods for measuring children's capacity to "learn how to learn". Children also will develop critical thinking and life skills related to building a democratic society, promoting respect for human rights and justice, appreciating diversity, tolerance, non-violence and conflict resolution and increasing self-esteem and creativity. Multi-media and multi-channel techniques will be investigated and developed to improve teacher training as well as classroom teaching.

51. Primary education services will address disparities, particularly based on gender. Efforts will include providing latrines and promoting hygiene education programmes in schools, recruiting female teachers, eliminating gender stereotypes from teaching and learning materials, sensitizing teachers to gender issues and increasing the participation of women in school planning and administration. Social mobilization and advocacy efforts will aim to involve the entire community in establishing a more "girl-friendly" educational environment.

52. Other groups will be targeted as part of the rights-based approach to education. As very poor urban children are especially disadvantaged, special efforts will be made to develop a more accurate understanding of their needs and motivations, with Government and NGO services to be developed and expanded accordingly. Approximately 1.5 million street children and working children living in urban slums will be provided with opportunities for education through over 8,000 schools and service centres. Measures also will be designed to remove working children from hazardous labour and to minimize the cost of their attending school. As a partner in a multi-donor consortium which is supporting the general education project, the BRAC NFPE programme and INFEP NFPE efforts, UNICEF will continue to contribute to providing supplies and support for NFPE classrooms.

Health and nutrition

53. Health and nutrition interventions will continue to focus on survival by targeting the poorest 20 per cent of the population and to address the continued high incidence of IMR, MMR and the main causes of under-five mortality - diarrhoea, pneumonia and malnutrition. Universal coverage of new interventions will build on the already high coverage of the immunization programme. Services related to child development and protection will include communication efforts to promote life skills at outreach service delivery sites and through child-to-child activities in schools. The private sector and NGOs will be crucial links to community-level care provisions. Special attention will be given to reaching the hard-core poor in urban areas and the Chittagong Hill Tracts.

54. The health services package will include improvement of the quality of services for maternal and child survival. The outreach package (through EPI outreach sites, and to a lesser extent, schools) will include immunization, vitamin A, growth monitoring and promotion, family planning, iron supplementation, counseling, antenatal and post-natal care, pneumonia and diarrhoea case management, provision of ORS, safe birth kits, contraceptives (provided by other donors) and demonstration sites for smokeless stove, sanitary latrines and tube-wells. Child-to-child approaches will be used to extend messages to siblings and other family members. At the household level, the health services package will include family planning information (and services aided by other donors), registration of pregnant women and newborns, exclusive breast-feeding, safe delivery, health education, disease surveillance and immunization campaigns. The convergent delivery of services will promote integration of training, logistic management, disease surveillance and

monitoring for personnel. Innovative projects will focus on double fortification of salt and cost-sharing.

55. Other strategic interventions include polio immunization for children up to five years of age, quarterly measles campaigns and ensuring a high level of vaccination with five doses of tetanus toxoid among females 14-45 year of age and school-going children, especially girls. In diarrhoea management, the focus will be on ensuring correct case management at the referral levels while maintaining the high ORT use rate. For ARI, especially pneumonia, the emphasis also will be on ensuring correct case management at the health-facility level and timely referral by caretakers. The programme also will focus on the correct use of antibiotics by front-line workers. Other selected interventions will include malaria control in the Chittagong Hill Tracts and dissemination of information on HIV/AIDS as part of a Facts For Life package. The nutrition programme will focus on selective food and nutrient supplementation and on the promotion of breast-feeding and mother and child nutrition. The IDD programme will continue to focus on monitoring of production and consumption, and the promotion of the exclusive use of iodated salt. At the household level, the primary care component of emergency obstetric care will include promotion of clean delivery and widespread knowledge about the early signs of complications and need for referral.

Water supply and sanitation

56. Building on widespread success in water supply efforts, the new programme will shift emphasis from service delivery to empowerment and behavioural change for improved sanitation and hygiene practices. Advocacy, social mobilization and communication will be used for outreach to communities, particularly women, and to involve them more fully in the programme. Emphasis will be given to enhancing sustainability, including capacity-building of government and private sectors. UNICEF will withdraw from (a) tube-well installation in high water-table areas, where large numbers of private suction tube-wells are being installed; (b) subsidizing the production of concrete latrine parts as the private and NGO sector are fast expanding; and (c) rehabilitating defunct water systems as the Government takes over this activity.

57. In the water supply sector, the programme focuses on disparity reduction, with major inputs in the underserved coastal belt, Chittagong Hill Tracts and stony areas and the expanding area with a low water-table. In the sanitation sector, priority will be given to reducing the high pathogen load of human excreta deposited every day in the public domain. A range of low-cost sanitary latrine technology, including "do-it-yourself" homemade latrines, will be promoted at family and community levels. Periodic mass deworming and provision of nail-clippers will complement the water supply, sanitation and hygiene package. The use of naturally composed human excreta as fertilizers in latrine pits will be promoted. The involvement and training of various partners such as the network of 45,000 schools, 14,000 NGOs, 4,500 union parishads (subdistricts), religious leaders and social clubs, plus over 40,000 field workers, will be central to the motivation of communities to change their behaviour. Most of the primary schools, the 2,500 health centres and the 108,000 EPI outreach centres will be provided with sanitary latrines, smokeless stoves and water facilities, which also will serve as demonstration units. A wider use of smokeless stoves should reduce the incidence of pneumonia and skin infections among children, as well as economize on use of fuel.

58. Greater emphasis will be given to the urban slum and fringe populations. Communities will be organized for more effective participation in the programme, which includes the promotion of self-financed family sanitary latrines to be funded by parents themselves, and community latrines to be operated on the "pay as you use" concept to generate maintenance funds. Other activities include the promotion of low-cost community water supplies, biogas plants and hygiene

education. The capacity of the over 100 municipalities (pourashavas) and the city corporations implementing the project will be enhanced through staff training. UNICEF assistance will be largely in the form of full-scale demonstration activities, innovations and system testing in such areas as rainwater collection. In the area of research and development, UNICEF assistance will address the decline of the groundwater table below the suction limit of tube-wells, as well as latrine designs, harvesting of rainwater from rooftops and other environment-friendly technologies.

Integrated basic services

59. The delivery of urban basic services will shift from a focus on slum improvement towards the universal provision of basic services, although the poor will continue to be the principal target population. However, the strengthening of local planning structures will be emphasized in order to strengthen effective coordination of services. UNICEF will assist the Government in establishing 1,000 urban service centres in four major metropolitan areas, where more than 50 per cent of the total 2 million very poor urban population live. A variety of services, especially those for such marginalized groups as women and children in especially difficult circumstances, will be delivered through the service centres, each of which will provide access to approximately 2,000 people. An estimated 600 children between 6 and 14 years of age will benefit from each centre.

60. Street children also will be served through 1,000 service centres. In addition to providing education for working children, UNICEF will address the needs of approximately 2 million children living in urban slum communities who have little or no access to primary education. According to a rapid assessment of child labour in Bangladesh, a significant number of those 2 million children are working. The ultimate objective is regulation and eventual elimination of child labour, although progress will be phased over a number of years. Partners in the effort range from the private sector to NGOs and various government ministries.

61. Children in conflict with the law and disabled children, as well as gender and development issues, will be addressed through strengthening the capacity of government agencies for policy planning and development. Activities related to the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women also will be taken up under this project. For example, support will be provided for the development and implementation of a national children's policy and policies on childhood disability, juvenile justice and the establishment of a National Children's Council.

62. Issues related to disaster preparedness and response will be incorporated into all programmes. A project implemented with the Disaster Management Bureau, sister agencies in the United Nations system and other partners will strengthen community-level capacity to undertake actions for saving lives in disaster situations. Interventions also will be designed to protect property, minimize trauma, prevent the separation of children from their families and minimize effects on social and economic development processes. UNICEF will design a computerized disaster assessment and response system for use in Bangladesh and possibly elsewhere.

63. In the Chittagong Hill Tracts, efforts will cover most of the 1 million inhabitants in the three districts, nearly one half of them tribal groups. The goal is to achieve significant improvements in health, education and water supply and sanitation, thus reducing disparities. Consistent with the child and women's rights and accelerated district approaches, activities will respond to the needs of communities on the basis of participatory appraisals. Activities

will be planned and implemented by communities, based on use of the DISIDE system, and managed in a decentralized fashion.

64. The objective of continued UNICEF assistance to the Grameen Bank project will be to strengthen the socio-economic and environmental impacts of the activities of Bank members. Major objectives will be the enhancement of organizational and management skills, improvements in health and nutrition and education of members and their children, especially adolescent girls. Innovations in the development of environment-friendly technologies also will be promoted. With an emphasis on the rights-based approach, support will be provided for the adoption of credit programmes by such previously marginalized groups as people in the Chittagong Hill Tracts or in particularly disaster-prone areas.

Country programme evaluation plan

65. Five districts already have been chosen to undertake the ADA approach beginning in the latter half of 1994. This experience will be useful for the implementation of ADA in 15 districts in 1996. A major review will be undertaken towards the end of 1997 to make necessary mid-course corrections and changes in strategies and programme design. This will be supported by triennial review meetings between the Government and UNICEF. Annual work planning meetings in which donors and NGOs also will participate will help to enhance the planning and programming capacity essential to the success and sustainability of ADA. A set of indicators has been developed to monitor the processes that would lead to local capacity-building and empowerment. The over 5,000 field-trip days by UNICEF staff will be used not only to monitor those processes, but also to strengthen local planning and programming capacities by organizing training sessions on the use of DISIDE. Coverage indicators will be monitored annually through routine reports and the use of MIS.

66. The country programme as a whole is more than the sum of its parts. Progress in its implementation will be kept under constant review through special studies and evaluations and periodic internal and external audits. Given the present uncertainty about the future shape of the local government structure, the role and status of the district commissioner, the lack of consensus among technocrats and bureaucrats and the evaluation of the decentralization process, the 1997 programme review will focus particularly on those issues. The review also will provide an opportunity to realign UNICEF-assisted programme strategies with major social sector projects of donor consortiums working in Bangladesh.

Programme management

67. The proposed programme of cooperation is a part of the Government's development plan and national budget. JGUAG acts as the main coordinating mechanism for the programming and utilization of UNICEF assistance.

68. The implementation of ADA will require a close working relationship between the subnational bureaucracy and the UNICEF staff based in four divisional offices. Using MIS, a "challenge factor" has been developed that allows the classification of districts based on their level of progress towards achievement of goals and the development of infrastructure. Weaker districts require more support in terms of technical and financial inputs. The UNICEF division office staff will be redeployed and provided with the skills necessary to meet the challenge. Similarly, staff in the country office in Dhaka will be responsible for specific districts so as to encourage intersectoral linkages and to provide greater support to division office teams.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Bangladesh		(1992 and earlier years)		UNICEF country classification	
Under-five mortality rate		122	(1993)	High USMR	
Infant mortality rate		94	(1993)	Very high IMR	
GNP per capita	\$	220	(1992)	Low-income GNP	
Total population		122.2 million	(1993)		
KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1993
Births	(thousands)	3222	4070	4394	4712
Infant deaths (under 1)	(thousands)	477	529	455	443
Under-five deaths	(thousands)	770	859	613	575
Under-five mortality rate (per 1,000 live births)		239	211	140	122
Infant mortality rate (under 1) (per 1,000 live births)		148	130	104	94
		About 1980	Most recent		
Underweight children (under 5)	Moderate & severe	71 *	68 **		
(% weight for age, 1986/1992)	Severe	31 *	25 **		
Babies with low birth weight (%, 1983/1990)		47	50		
Primary school children reaching grade 5 (%, 1980/1989)		20	47		
NUTRITION INDICATORS		About 1980	Most recent		
Exclusive breast-feeding rate (<4 mos.) (%)		..	..		
Timely complementary feeding rate (6-9 mos.) (%)		..	..		
Continued breast-feeding rate (20-23 mos.) (%)		..	..		
Prevalence of wasting (0-59 mos.) (%, 1986/1992)		15 *	17 **		
Prevalence of stunting (0-59 mos.) (%, 1986/1992)		68 *	64 **		
Daily per capita calorie supply (% of requirements, 1979-1981/1988-1990)		80	88		
Total goitre rate (1981)		11	..		
Household expenditure (% of total income, 1980-1985)	All food/cereals	..	59 / 36		
HEALTH INDICATORS		About 1980	Most recent		
ORT use rate (%, 1986/1994)		51	61		
Access to health services	Total	45	52		
(% of population, 1985/1992)	Urban/rural	.. / ..	.. / ..		
Access to safe water	Total	38	97		
(% of population, 1980/1994)	Urban/rural	26 / 40	99 / 97		
Access to adequate sanitation	Total	4	34		
(% of population, 1980/1994)	Urban/rural	21 / 1	75 / 30		
Births attended by trained personnel (%, 1988/1994)		5	10		
Maternal mortality rate (per 100,000 live births, 1985/1992)		600	470		
Immunization		1981	1985	1990	1993
One-year-olds (%) immunized against:	Tuberculosis	1	3	86	95
	DPT	1	2	62	74
	Polio	1	2	62	74
	Measles	1	3	..	71
Pregnant women (%) immunized against:	Tetanus	1	3	74	80

* Aged 6-59 months.

** Aged 6-71 months.

TABLE 1 (continued)

Bangladesh

EDUCATION INDICATORS		About 1980		Most recent		
Primary enrolment ratio (gross/net) (%, 1980/1990)	Total	58 / ..		77 / 69		
	Male	72 / ..		83 / 74		
	Female	43 / ..		71 / 64		
Secondary enrolment ratio (gross/net) (%, 1980/1990)	Total	17 / ..		19 / 17		
	Male	25 / ..		25 / 22		
	Female	9 / ..		12 / 11		
Adult literacy rate, 15 years & older (%, 1981/1992)	Total	29		40		
	Male/female	40 / 18		47 / 25		
Radio/television sets (per 1,000 population, 1980/1991)		17 / 1		43 / 5		
DEMOGRAPHIC INDICATORS		1970	1980	1990	1993	2000
Total population	(thousands)	66671	88221	113684	122210	144265
Population aged 0-15 years	(thousands)	31658	43045	49854	52503	59142
Population aged 0-4 years	(thousands)	12195	15043	17445	18689	21277
Urban population (% of total)		7.6	11.3	16.4	18.4	22.9
Life expectancy at birth (years)	Total	44	48	52	53	56
	Male	45	48	52	53	56
	Female	43	47	52	53	56
Total fertility rate		7.0	6.4	4.9	4.7	4.2
Crude birth rate (per 1,000 population)		48	46	39	38	35
Crude death rate (per 1,000 population)		21	18	14	13	11
		About 1980		Most recent		
Contraceptive prevalence rate (%, 1991)		..		40		
Population annual growth rate (%, 1965-1980/1980-1993)	Total	2.8		2.5		
	Urban	6.7		6.3		
ECONOMIC INDICATORS		About 1980		Most recent		
GNP per capita annual growth rate (%, 1965-1980/1980-1992)		-0.3		1.8		
Inflation rate (%, 1970-1980/1980-1992)		21		9		
Population in absolute poverty (%, 1977)		Urban/rural 86 / 86		.. / ..		
Household income share (%, 1989)		Top 20%/bottom 40%		39 / 23		
Government expenditure (% of total expenditure)	Health/education	.. / ..		5 / 11		
	Defence	..		10		
Household expenditure (% share of total, 1980 or 1985)	Health/education	.. / ..		2 / 1		
Official development assistance: (1981/1992)		\$US millions As % of GNP		1096 9		1728 7
Debt service (% of goods and services exports, 1982/1992)		18		14		

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1993-1995 ^{a/}

COUNTRY: BANGLADESH
LATEST BOARD APPROVAL: 1993
GENERAL RESOURCES: \$52 800 000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		General resources		TOTAL SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health and nutrition	5 031	7 372	734	384	204	380	3 133	4 374	9 102	17 631	12 510	30 414	21 612	48 045
Water supply and sanitation	370	4 592	366	272	278		437	6 318	1 451	4 395	11 182	24 427	12 633	28 822
Education	1 491	602	36		148		3 595	3 045	5 270	13 020	3 647	23 405	8 917	36 425
Urban basic services	64		155				1 997		2 216	2 865		660	2 216	3 525
Women-centred programme	43	1					715	47	758	1 950	48		806	1 950
Children in especially difficult circumstances	50		54				261		365	900			365	900
Information, advocacy and social mobilization	354		201	3	148		571	262	1 274	2 280	265		1 539	2 280
Planning, monitoring and evaluation	262		169				1 083		1 514	1 866			1 514	1 866
Programme support	260				498		3 999	227	4 757	5 193	227		4 984	5 193
Disaster preparedness	3	735	2				84	413	89	600	1 148	900	1 237	1 500
Area-based project										2 100		2 015		4 115
GRAND TOTAL	7 928	13 302	1 717	659	1 276	380	15 875	14 686	26 796 b/	52 800	29 027	81 821 c/	55 823	134 621

GR = General resources.

FSF = Programmes approved for funded supplementary funding.

SF = Programmes for supplementary funding, funded and unfunded.

^{a/} Actual expenditures include expenditures recorded as of November 1994.

^{b/} Including expenditures from global fund and additional allocation of general resources for unfunded programmes for supplementary funding.

^{c/} Of this amount \$41 647 100 remains unfunded.

TABLE 3. PLANNED EXPENDITURE, 1996 - 2000

(In thousands of United States dollars)

Country: BANGLADESH		Funding					
Period covered: 1996 - 2000		status	1996	1997	1998	1999	2000
Health and nutrition	GR		4 000	3 500	3 000	3 000	3 500
	NSF		4 000	9 500	13 000	17 000	11 500
Water supply and sanitation	GR		1 500	1 000	1 000	1 000	1 000
	NSF		5 500	6 000	7 500	7 000	4 000
Education	GR		5 000	5 500	6 000	5 000	5 000
	NSF		7 000	12 500	18 000	23 000	17 000
Monitoring, evaluation and research	GR		500	500	500	500	500
Advocacy and planning support	GR		1 000	1 000	1 000	1 000	1 000
Urban basic services	GR		1 500	1 500	1 500	1 500	2 000
Grameen bank	GR		500	500	500	500	500
Chittagong hill tracts	GR		1 000	1 500	1 500	2 000	1 500
Disaster preparedness	GR		1 000	1 000	1 000	1 000	1 000
Programme communications	GR		1 500	1 500	1 500	1 500	2 000
TOTAL	GR		17 500	17 500	17 500	17 000	18 000
	NSF		16 500	28 000	38 500	47 000	32 500
GRAND TOTAL			34 000	45 500	56 000	64 000	50 500

GR = General resources.

NSF = New programmes for supplementary funding.
